

REQUEST FOR RELEASE OF PET MEDICAL RECORDS

TO: Practice Name _____

Address _____

Phone # _____ Fax # _____

I hereby request that the medical records or copies of such medical records for my pet(s) be released to:

**Community Pet Health Center
17414 O'Connor Road
San Antonio, TX 78247
Phone (210) 653-9314**

PLEASE FAX TO

Fax (210) 653-0422

Date: _____

Owner's Name: _____

Address: _____

Pet Name(s): _____

Signature: _____