

REQUEST FOR RELEASE OF PET MEDICAL RECORDS

Please fax completed form to 210-653-0422. (Please allow up to 48 hours for records to be transferred or be available for pick up.)

Date: _____

Owner's Name: _____

Address: _____

Pet Name(s): _____

Signature: _____

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

____ I will pick up my pet(s) medical records in person.

____ Practice Name _____

Address _____

Phone # _____ Fax # _____

Email: _____