Affordable Vet Care
1906 E 8th Street, Trenton, MO 64683 Phone
(660)359-7808 Fax (660) 359-2406

# AUTHORIZATION FOR VETERINARY MEDICAL RECORDS RELEASE

Regarding the confidentiality of patient medical records, a written authorization is requested in order for Affordable Vet Care to forward a digital copies of your pet's medical records. Medical records released shall not contain any sensitive personal or financial information about the owner. Only medical treatment records shall be released. If paper copies are requested a fee will apply to cover the costs associated with producing those copies that the owner will be required to pay before receiving those copies.

**CLIENT/OWNER INFORMATION**

| | | | |
|---|---|---|---|
| Name: | | | |
| Address: | | Email: | |
| City: | State: | Zip Code: | Phone: |

**PET INFORMATION**

| | |
|---|---|
| Name: | Breed: |
| Name: | Breed: |
| Name: | Breed: |

**RELEASE PETS MEDICAL RECORDS TO**

| | | | |
|---|---|---|---|
| Name of Veterinary Practice/Boarding Facility: | | | |
| Address: | | Email: | |
| City: | State: | Zip Code: | Phone: |
| FAX: | | Attn: | |
| Other: | | | |

**REASON FOR REQUEST**

□ Relocation □ Primary Veterinary Copy □ Referral to Specialist
□ Second Opinion □ Groomer/Boarding Facility
□ Other _____

**Please include copies of**: □ Exam Results □ Radiology/Xray Copies & Reports
□ Vaccination Records
□ Laboratory Results □ Surgery Reports □ Entire Medical Records ------
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I hereby certify that I am the owner or the authorized agent of the owner of the above-described pet(s). I hereby request and authorize Affordable Vet Care to release the requested medical information for my pet(s).

**Signature of Owner**_____ **Date**_____

Print Name: _____

***For Staff Use Only***

*Patient files reviewed by Veterinarian:*
*Patient files were faxed to:* *date:* *by:*
*Patient files were mailed to:* *date:* *by:*
*Patient files were given to:* *date:* *by:*