LIBERTY
VETERINARY MEDICAL CENTER

Medical Records Release Authorization

Date: _____

Owner: _____ Patient: _____

Species: _____ Breed: _____ Sex: _____ Altered: _____

Address: _____

Phone: _____ Email Address: _____

Reason For Medical Record Release:

_____

Choose one option below:

As the legal owner/agent of above listed animal, I authorize Liberty Veterinary Medical Center to release medical treatment records from this date forward, as requested by myself, to any person/business/entity of my choosing for the purpose of verifying veterinary medical care:

_____

Client/Owner Signature Printed Name Date

As the owner/agent of the above listed animal, I am requesting my pet's entire medical record be forwarded from Liberty Veterinary Medical Center to the below listed veterinary clinic or myself and approve this release:

_____

Person or Veterinary Clinic to Receive Medical Records

_____

Client/Owner Signature Printed Name Date