PATIENT RELEASE OF MEDICAL RECORDS

Owner's Name: Owner's Phone Number:

Owner's Address: Street

City State AL Zip

Pet's Name: Species: Breed: Sex:

Age: W/M/Y: Color:

I, , the owner or authorized agent for the above mentioned pet, request and give my permission to release the medical records for my pet from the following veterinary hospital/clinic:

Previous Veterinary Hospital Information

Hospital Name

Previous Doctor

Address

City State AL Zip

Please forward a copy of my pet's records to:

Staring Plaza Veterinary Center
162 Staring Lane
Baton Rouge, LA 70810
(225) 766-8333
(225)766-8334 Fax
dogandcatdocs.com

Signature of Owner/Agent: _____

Print Form