Authorization for Veterinary Medical Records Release

In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, a written authorization is required in order for B.E.S.T. VETS Animal Hospital to produce copies of your pet's medical records. Medical records released shall not contain any sensitive personal or financial information of the owner. Only medical treatment records shall be released.

Client Information:

Name: _____ Phone: _____
Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____

Pet Information:

Name: _____ Species: _____ Breed: _____ DOB: _____
Name: _____ Species: _____ Breed: _____ DOB: _____
Name: _____ Species: _____ Breed: _____ DOB: _____

Additional forms will need to be completed in the event you cannot fit all animals on this page or if they are to be sent to multiple locations

Release Medical Records to:

I authorize release of medical records to any and all facilities/individuals who request records verbally and/or in writing.
_____ (initial)

OR

Facility and/or Individual Name: _____
Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____
Fax: _____ Phone: _____

Reason for Request:

☐ Relocation ☐ Referral to Specialist ☐ Second Opinion ☐ Boarding/Grooming ☐ Other:_____

Please Include Copies of:

☐ Vaccination Records ☐ Standard Medical Records ☐ Other:_____

I hereby certify that I am the owner, or authorized agent of the owner, of the aforementioned pet(s). Further, I hereby request and authorize B.E.S.T. VETS Animal Hospital to release the requested medical information for my pet(s). I understand that this authorization will remain in effect unless revoked or cancelled in writing.

Name of Owner/Agent: _____
Signature of Owner/Agent: _____ Date: _____

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OFFICE USE:
MANAGEMENT NOTFIED (Note Specific Details):
Other Comments: