

# Authorization to Release Information

I authorize the College Mall Veterinary Hospital to release medical record Information, as needed regarding \_\_\_\_\_ either by fax, mail or over the phone to the following:

(Pet's Name)

**(PLEASE CHECK ANY/ALL THAT MAY APPLY TO YOUR PET)**

- Boarding Kennel**
- Grooming Facility**
- Day Care Facility**
- Dog Park**
- Training Facility**
- Family Members**
- Rescue Organizations or Animal Shelters**
- New Owner**
- Pet Sitter**
- Other** \_\_\_\_\_

I understand that the original medical record (including radiographs) will remain the property of College Mall Veterinary Hospital.

College Mall Veterinary Hospital and its employees are released from legal responsibility or liability for the release of this information to the extent indicated and authorized herein.

- NO, I DO NOT WANT MY PET'S MEDICAL RECORDS RELEASED**

\_\_\_\_\_  
Signature of Owner or Authorized Agent

\_\_\_\_\_  
Date

