

NEW PATIENT INFORMATION

Client's Name:

Pet's Name:

Dog/Cat:

Male/Female:

Spayed/Neutered:

Date of Birth:

Previous Vaccinations/Medical History
(include Rx):

Breed:

Color:

Microchip # or tattoo:

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 Kennels
- Day Care Facility
- Pet Sitter
- Dog Park
- Grooming Facility
- Training Facility
- Family Members
- New Owner
- Rescue Organizations, Animal Shelters
- 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