Brookings Animal Hospital

Authorization to Release Veterinary Records

PLEASE FAX THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE TO BROOKINGS ANIMAL HOSPITAL AS NOTED BELOW:

ATTN: ________________________________ FAX: _________________________________

Pet Parent Information:

Name: ____
Address: ____
City: ____________________ State: ______ Zip Code: _________ Phone: _________________

Pet Information:

Name: _____________________________________ Breed: _______________________________
Name: _____________________________________ Breed: _______________________________
Name: _____________________________________ Breed: _______________________________
Name: _____________________________________ Breed: _______________________________

Please include copies of:

☐ Vaccination Records ☐ Laboratory Reports ☐ Exam Reports ☐ Surgery Reports
☐ Pathology/Biopsy Reports ☐ Radiology/X-Ray Reports ☐ Entire Medical Record _______________
(Date Range)

Please e-mail x-rays and lab results to our secured e-mail at animal_hospital@bellsouth.net

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I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Furthermore, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to Brookings Animal Hospital. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

PET PARENT SIGNATURE: ____ **DATE:** ______________