TO: Malvern Veterinary Hospital
545 S. Warren Avenue
Malvern, PA 19355

I request that copies or summaries of the medical records of my pet(s) named:

____

____

be released to:

____

Company Name

____

Street Address City State Zip

I acknowledge that payment of $ 1.00 per page must be received for you to photocopy and mail or fax this information as directed. Our staff will contact you with the fee.

Please check one of the options below:

_____ Please mail copies of my records to the requested address

_____ Please fax copies of my records to the requested address

Fax number _______________________________

____

Signature of Owner Date

For Staff use only

____

Veterinarian's Approval Date

____

Staff Signature Date