Compassionate Care Veterinary
198 Grandview Lane
Norwich, NY 13815
607-334-4545
Fax: 607-334-9692

Authorization to Release Veterinary Records To

Clinic Name______________________________ **Fax No.**____________

Pet Parent Information:
Name:
____
Address:
____

City: ________________ State: _______ Zip Code: _______ Phone: ____________

Pet Information:

Name: ________________________ Breed: ________________________

Name: ________________________ Breed: ________________________

Name: ________________________ Breed: ________________________

Name: ________________________ Breed: ________________________

Name: ________________________ Breed: ________________________

Date Range: ____________________ **to** ________________________

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to the above listed veterinarian/veterinary clinic.

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:** __________

OR

VETERINARY CLINIC SIGNATURE: ______________________ **Date:** __________