

Pittsford Animal Hospital

2816 Monroe Avenue
Rochester, NY 14618
Telephone: (585) 271-7700
Fax: (585) 244-7287

Client Name _____ **Acct#** _____

MEDICAL RECORDS RELEASE FORM

I, the undersigned do hereby grant my permission for the release of any or all of the information contained in the medical records of those pets listed below to the following person or Veterinary practice:

PET NAME(S) FOR RELEASE OF MEDICAL RECORDS

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Release RECORDS TO: _____

Date: _____ **FAX#** _____

REASON FOR REQUEST OF RECORDS:

CLIENT SIGNATURE

DATE