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AUTHORIZATION FOR RELEASE OF VETERINARY MEDICAL RECORDS

Metro Paws has set forth certain policies regarding the health and medical care of all canines entering our facility. In order to continue our efforts to monitor the health of our canine clients, we here at Metro Paws need full disclosure of veterinary records.

Veterinary Facility: _____ Veterinary Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please release a copy of all veterinary records, including but not limited to, vaccination records upon request.

Patient Information (please fill out with the information on file at your veterinary office)

Client Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Pet Name: _____ D.O.B./Age: _____

Breed: _____ Color: _____

Pet Name: _____ D.O.B./Age: _____

Breed: _____ Color: _____

BY MY SIGNATURE, I AUTHORIZE RELEASE OF ALL VETERINARY RECORDS.

Signature: _____ Date: _____