ST. CHARLES VETERINARY HOSPITAL
38973 US Highway 27 Davenport, FL 33837
Phone: 863-438-6600 Fax: 863-438-6603

Patient Label

AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

I authorize St. Charles Veterinary Hospital to release the above named patient medical records to:

Referring Veterinarian Name:	
Referring Veterinarian Address (if known):	
City/State/Zip Code:	
(Area Code) Phone:	(Area Code) Fax:
Email Address:	

Description of information that may be disclosed:

- ◯ Dates of service From: _____ Through: _____
- ◯ Laboratory Results
- ◯ Imaging Results (Radiographs, Ultrasound, etc.)
- ◯ Entire Medical Record

This information will be used/disclosed for the following purposes:

- ◯ Continuity/Transfer of Care
- ◯ Legal
- ◯ Insurance/Payment of Bills
- ◯ Other: _____

Owner Signature:_____ Date:_____
Please return signed and completed form via fax to (863) 438-6603, email to stcharlesvethospital@gmail.com, or mail to 39873 Hwy 27, Davenport, FL 33837

Internal Use Only: Doctor Authorization:_____ Date:_____
Records Sent Via: Fax Email Pick Up By:_____ Date: _____