Request for Release of Medical Records

Owners Name:_____
(Last) *(First)*

I Request that copies or summaries, as required by state law, of the medical records pertaining to my animal (s) named_____
Be released to the following:

☐ **Veterinary Hospital** ☐ **Self** ☐ **Referral**

Records are to be fax _____email_____picked up_____.

_____
Name to submit to

_____
Street Address *City* *State* *Zip*
Fax Number of Recipient:_____
Email Address Of Recipient:_____@_____

Reason for request?

_____
_____

_____ ____/____/____
Signature of Owner or Authorized Agent *Date*

In accordance to Statute we will supply your records, to you, within 30 days of your written request and a fee will be charged of not more than 65 cents per page and reasonable postage if needed. All fee's and outstanding balances must be pre-paid before records will be released.

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*Dr Approved*_____*Date*_____
*Owner Paid*_____*Date*_____
Sent to D W Y _____*Date*_____
*Records sent*_____*Date*_____
Fax *Email* *On Clip*

*Owner Notified Amt Due*_____*Date*_____
*Records Printed*_____*Date*_____
*Review Complete*_____*Date*_____
*Owner Informed of Submission*_____
TCWO *LMOM*