Authorized Request of Medical Records

Previous Hospital/Clinic/Doctor Name_____

_____

Phone Number _____

Fax Number _____

I, _____ authorize the release of any and all Medical records of my animal while under your veterinarian care to ALL ANIMALS Veterinary Hospital.

Please fax my pet's medical and history record to (818)223-9147.

Pet(s) Name _____

Pet(s) Name _____

Pet(s) Name _____

Thank you,

Signature _____ Date _____