PetDocks Veterinary Hospital

AMERICAN ANIMAL HOSPITAL ASSOCIATION

# REQUEST FOR RELEASE OF MEDICAL RECORDS

To: ______________________________(Practice Name)

______________________________(City)

______________________________(State)

______________________________(Phone)

______________________________(Fax)

I hereby request that copies of the medical records including vaccine history of my pet(s) named:

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________ be released to:

**PetDocks Veterinary Hospital**
Fax # 252-240-3540

Owner's signature: _______________________________________ Date: _____________

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -