959 West Racine Street
Jefferson, WI 53549
920.674.2383 920.674.3250 fax

Consent for Release of Medical Records

Client Name_____

Address_____

City_____ State_____ Zip Code_____

Phone Number (_____)_____Alternate Phone (_____)_____

Pet(s) Name(s)_____

_____

I give my permission for the following information to be released:

_____Full access of information (complete copy of history)
(initial)

_____Release only Spay/Neuter, Vaccination and Heartworm History
(initial)

_____Other – specify information to be released_____
(initial)

_____

_____I am releasing ownership of this pet to the person or facility listed below
(initial)

Please provide the required information to where the information should be sent, or who is authorized to pick up the records:

Name of Clinic, Facility or Individual_____

Address_____

City_____State_____Zip Code_____

Phone (_____)_____Fax (_____)_____

_____ _____
Signature of owner, agent, or authorized individual Date