

REQUEST TO RELEASE MEDICAL FORMS



In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, a written authorization is required in order for Boca Palms Animal Hospital to produce copies of your pet's medical records. Medical records released shall not contain any sensitive personal or financial information of the owner. Only medical treatment records shall be released.

Owner's Name: _____

Current Address: _____

Contact :# _____ Email : _____

Co-Owner's Name: _____ Contact #: _____

Pet Information

Name: _____ Age: _____

Breed: _____ Sex: Male Female Spayed/Neutered

Reason for Request

Request to Send

- Vaccination Records only
 Standard Medical Record – Please allow 48 hours for Processing

Delivery

- Pick-Up Mail to current address Mail to my new address
 Email to Veterinarian: _____

Written Authorization

I hereby certify that I am the owner, or authorized agent of the owner, of the aforementioned pet(s). Further, I hereby request and authorize BPAH hospital to release the requested medical information for my pet(s). I understand that this authorization will remain in effect unless revoked or cancelled in writing.

Owner's Signature: _____

Print Name: _____

Co-Owner's Signature: _____

Print Name: _____

Date: ____ / ____ / ____