



FAX (901) 590-2615

Authorization to Release Veterinary Records

PLEASE FAX THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE  
TO HOTEL POOCHIE AS NOTED BELOW:

Attn: \_\_\_\_\_

Fax: \_\_\_\_\_

Pet Parent Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Pet Information:

Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Please include copies of:

Vaccination Records  
Pathology/Biopsy Reports

Laboratory Reports  
Radiology/X-Ray Reports

Exam Reports  
Entire Medical Record \_\_\_\_\_

Surgery Reports  
(Date Range)

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to Hotel Poochie. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

PET PARENT SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_