SKYLINE ANIMAL HOSPITAL
America's Premium Veterinary Healthcare

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AUTHORIZATION TO RELEASE VETERINARY RECORDS

PLEASE FAX THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE TO SKYLINE ANIMAL HOSPITAL AS NOTED BELOW

Attn: _____ Fax #: _____

PET PARENT INFORMATION:

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____

PET(s) INFORMATION:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

PLEASE INCLUDE COPIES OF:

☐ Vaccination Records ☐ Laboratory Records ☐ Exam Reports ☐ Surgery Reports

☐ Pathology/Biopsy Reports ☐ Radiology/X-Ray Reports ☐ Entire Medical Record _____

(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 SKYLINE ANIMAL HOSPITAL, LLC. 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: _____ Today's Date _____

Submit by Email Print Form