

**Fairview Veterinary Hospital
6735 Pittsford-Palmyra Road
Fairport, New York 14450**

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www.fairviewvet.com

Client Name _____ Acct# _____

Veterinary Medical Records Release Form

I, the undersigned do hereby grant my permission for the release of any or all of the information contained in the medical records of those pets listed below to the following person or Veterinary practice:

PET NAME(S) FOR RELEASE OF MEDICAL RECORDS

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Release Records to: _____

Date: _____ Fax# _____

REASON FOR REQUEST OF RECORDS:

****This release will remain in effect until you notify us in writing of any desired changes.****

CLIENT SIGNATURE

DATE

FAIRVIEW STAFF WITNESS

DATE