Authorization For Release Of Medical Records

Please complete and fax, mail, or deliver to your **existing** veterinary clinic.

Client Name ____

Pet Name(s) ____

Street address ____

City ____________________________ State _______ Zip Code ______________

Phone Numbers ____

Please release and send a copy of all of my medical records:

To me in person

By facsimile to: Nipomo Dog & Cat Hospital at 805-929-2858

By Mail to: Nipomo Dog & Cat Hospital
525 Sandydale Drive
Nipomo, CA 93444

By my signature I authorize release of medical records from:

Previous veterinarian or clinic name: ______________________________________

Client signature ___________________________________ Date______________

* Note to Client – Please send this completed form to your **existing** veterinary clinic. (NOT Nipomo Dog & Cat Hospital)

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