

Authorization to Release Veterinary Records

As an authorized agent of _____ (Client) , the owner of _____ (Patient); we request and authorize _____ (Veterinarian) to release the following Medical Information for the Patient in accordance with laws and regulations applicable to the release of Patient Medical records. **(1 to 2 bus. day turnaround)**

Records are being requested to establish a full health history for an upcoming appointment with us at **Liberty Vet Pets 265 S 20th Street, Philadelphia, PA 19103** Fax (888) 458-8587 or libertyvetpets@gmail.com

For any questions, concerns, or issues; please call (888) 458-8587

Records are being requested for your personal use:

Name		ADDRESS	
PHONE NUMBER	E-MAIL / FAX NUMBER		

(All Free)

(No Radiographs Prior to 2022)

Please send the Patient's Vaccination Records Full Medical History X-Rays Lab Work

I release the Veterinarian and staff members from any legal responsibility and liability or the release of information to the extent indicated as authorized herein.

Client Identifying Information

FULL NAME		ADDRESS	
PHONE NUMBER	E-MAIL	CLIENT ID NUMBER	

Patient Identifying Information

NAME	GENDER	D.O.B.	BREED

Client Signature

Date

* This release of Veterinary Records is governed by statutory and regulatory provisions, see American Veterinary Medical Association Confidentiality and Patient records summary of provisions via this link: <https://www.avma.org/Advocacy/StateandLocal/Pages?sr-confidentiality-patient-records.aspx>. Note that State Veterinary Medical Boards have the authority to interpret and enforce provisions of veterinary practice acts. If you have a question about how a particular State Law Provision applies to individual circumstances in that state, please contact your state's veterinary medical board which can be accessed here: <https://www.avma.org/KB/Resources/Reference/Pages/Vetrinary-State-Board-Web-sites.aspx> *

Please be Kind to the People Who Work Here!