



Reid Veterinary Hospital
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933 Queen Ave SW, Albany, OR 97321

Authorization to Release Veterinary Records

Client Information

Owner's Name: Last: _____ First: _____
Address: _____ City: _____
State: _____ Zip Code : _____
Phone: _____ Email Address: _____

Patient Information

Name: _____ Species: _____ Breed: _____
Name: _____ Species: _____ Breed: _____
Name: _____ Species: _____ Breed: _____

I authorize Reid Veterinary Hospital to release the above named patient medical records to:

Name of person OR Facility: _____
(Area Code) Phone: _____ (Area Code) Fax: _____
Email Address: _____
Why are records being released? : _____

Description of information that may be disclosed:

- Vaccination History Laboratory Results Entire Medical Record
 Medical History Imaging (Rads, US)

I hereby certify that I am the owner or authorized agent of the owner of the above described pet (s). Further, I hereby request and authorize the veterinarians at Reid Veterinary Hospital to release the requested medical information for my pet (s) to the requested person/company named above. 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 30 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.

Client Signature: _____ Date: _____

