Union Pet Hospital

9842 Old Union Road
Union, KY 41091
Telephone: 859-384-7702
Fax: 859-384-7905

Authorization to Release Veterinary Records

Pet Owner Information:

Name: ____

Address: ____ Telephone: _________________

City: ____________________________________ State: ___________ Zip Code: __________________

Pet Information:

Name: ____ Breed: _____________________

Name: ____ Breed: _________________________

Name: ____ Breed: _________________________

Union Pet Hospital has my permission to release information contained in the Medical Record of the above named pet(s).

The information to be released includes:

_____ Entire Medical Record _____ Vaccination History Only

Union Pet Hospital will provide the information requested above to the following party:

Name: ____ Telephone: __________________

Address: ____ Fax: _______________________

City: ______________________________ State: ______________ Zip Code: ___________________

I hereby certify that I am the pet owner or authorized agent of the pet owner of the above described pet(s). Further, I hereby request and authorize Union Pet Hospital to release the requested medical information for my pet(s) to the above named facility. I release the Union Pet Hospital veterinarians 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 in writing at any time, but the revocation may not be applied retroactively once the information specified herein has been released.

Pet Owner Signature: ____ **Date:** _________________