Authorization to Release Veterinary Records

I hereby authorize the release of medical records for the pet(s) named below to:

ERLANGER PET RESORT & DAY SPA
3404 Dixie Highway
Erlanger, KY 41018
Telephone # 859-727-3940 Fax # 859-342-2255

Previous Veterinary Hospital Information:

Name: ______________________________ Telephone: ______________

Address: ______________________________ Fax: ______________

City: ________________ State: __________ Zip Code: ______________

Pet Owner Information:

Name: ____

Address: ______________________________ Telephone: ______________

City: ________________ State: __________ Zip Code: ______________

Pet Information:

Name: ________________________---__________ Breed:

____

Name: ______________________________ Breed: ______________

Name: ______________________________ Breed: ______________

The information to be released includes:

_____ Entire Medical Record _____ Vaccination History Only

I hereby certify that I am the pet owner or authorized agent of the pet owner of the above described pet(s). This authorization expires ONE YEAR 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: ______________