Authorization to Release Veterinary Medical Records

PLEASE FAX THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE

TO ACTIV4PETS (888-414-5915) AS NOTED BELOW:

Pet Owner Information:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email address: _____

Pet Information:

Name: _____Breed: _____ DOB: _____

Veterinarian or Hospital Contact Information

Veterinarian / Hospital Name:_____

Address: _____

Phone: _____Fax:_____

The information to be released:

_____Entire Medical Record ____Vaccination History Only ____Current Vaccination Status

I hereby certify that I am the owner or authorized agent of the owner of the above-described pet. Further I hereby request and authorize you to release the medical information for my pet to Activ4Pets. I release you and the staff from any and all legal liability for the release of information to the extent indicated and authorized herein. This authorization will expire within ___ year (s) from the date of signature. Please release my records to Activ4Pets fax number: (888)-414-5915 or please mail to: Activ4Pets, 250 Catalonia Ave, Suite 804, Coral Gables, FL 33134.

Owner or Owner's Agent Signature **Date**