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: Vaccine history, all blood and lab results and treatment summary.

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. 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.

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