**Veterinary Medical Records Release Form**

Highland Animal Hospital

687 Cleveland Ave. S. St. Paul, MN, 55116

651-698-0818

**Pertaining to:**

Initial one

\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ only

 (Patient Name)

\_\_\_\_\_\_ all pets on my account with Highland Animal Hospital

I hereby authorize my veterinarian and/or veterinary hospital to release the following veterinary medical records, lab reports, and/or radiographs.

**This permission is acknowledged for:**

Initial one

\_\_\_\_\_\_ One time use for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (Name of facility requesting records)

\_\_\_\_\_\_ Present and future use for requesting organizations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (Printed) Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date