Medical Records Request Form

Pet Parent Information:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

Pet Information:
Name: _____ Breed: _____
Name: _____ Breed: _____
Name: _____ Breed: _____

Please include copies of:
☒ Vaccination Records ☒ Laboratory Reports ☒ Exam Reports ☒ Surgery Reports ☒ Pathology/Biopsy Reports ☒ Radiology/X-Ray
☒ Entire Medical Record _____
(*Date Range*)

Release To:

☒ Mail records ☒ Fax Records ☒ E-mail Records
(please fill out appropriate information below)

Name/Business: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone:_____ Fax: _____
E-mail: _____

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to the above listed contact. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein.

PET PARENT SIGNATURE: _____ **Date:** _____

Please fax completed form to (316) 722-4172 or e-mail to doghouse@bogueanimalhospital.com.