

Authorization to Release Veterinary Records

Pet Owner Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

Telephone: _____

Pet Information:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

The information released may include:

Entire Medical Record Vaccination History Only Current Vaccination Status Only
(Please choose only the one that applies)

Ceglinski Animal Clinic will provide the information requested above to the following upon request:

1) Veterinarian 2) Boarding Facility 3) Groomer 4) Trainer 5) Other

Please mark out any of these that you would rather not share your pets medical records with.

I hereby certify that I am the owner of the authorized agent of the above described pet(s). Further, I hereby request and authorize Ceglinski Animal Clinic to release the information requested. I release their veterinarians and staff from any and all legal liability for the release of the information to the extent indicated and authorized herein. I may revoke this authorization in writing at any time. The Ceglinski Animal Clinic policy is to provide the requested release within two days of the written request.

X _____ Date: _____

Owner or Owner's Agent Signature

Ceglinski Animal Clinic 5401 Blandville Road Paducah, KY 42001 Phone (270)554-0171

