Atlantic
VETERINARY HOSPITAL

***Medical Records Release***

Date _____

Client Name _____

Street Address _____

City _____ State_____ ZIP _____

Home Phone _____ Cell Phone _____

Pet(s) name(s) _____

_____

I authorize the release of all medical records of the pets listed above to be faxed to Atlantic Veterinary Hospital. Please include all laboratory results, doctors' progress notes, and vaccinations schedules.

Signature _____
Pet owner or authorized agent

Print Name _____

Previous Veterinarians _____

Atlantic Veterinary Hospital Fax: 206-720-6248 Phone: 206-323-4433