1990 State Route 96
Phelps, NY 14532
Telephone: 315-548-8321
Fax: 315-548-3589

Date Requested:_____________________

Client Name: (first) ______________ (last) ________________

Mailing Address: _______________________________________

City, State, Zip: _______________________________________

I hereby authorize ______________________________ to release my pet's/pets' record(s) to:

Phelps Veterinary Hospital
1990 State Route 96
Phelps, NY 14532
Name of Veterinary Practice

Reason for records transfer: ______________________________________

Or

other specific parts of the record, i.e. X-ray's / Lab: _________________
Specific part

Client Signature: _______________________ Date: __________________