STACK HOSPITAL FOR PETS
104 Clinton Street
Fayetteville NY 13066
Phone (315) 637-9815
Fax (315) 637-9817

Request for Release of Medical Records

Name:_____ Address:_____
_____
_____

To: _____ (practice name and address with patient records)

I request that copies or summaries, as required by state law, of the medical records pertaining to my animal(s) named _____ be released to the following veterinary practice or other party by fax or surface mail or by email:

_____
Name of Practice or Other Party

_____
Street Address City State Zip

Fax Number of Recipient _____

Payment of $_____ is enclosed as payment of the fee required to photocopy and mail this information as directed.

I hereby authorize and provide my written consent to this transfer of medical information.

_____ _____
Signature of Owner or Authorized Agent Date

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_____ _____
Signature of Veterinarian Who Approves This Request Date