

MEDICAL RECORD REQUEST FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Patient Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Alternate Phone: (     ) \_\_\_\_\_

Reason for Request:  Boarding Facility     Grooming Facility     Relocation: \_\_\_\_\_

New Address

Veterinary Facility:  Specialist \_\_\_\_\_

Name

Reason for Visit

Family Veterinary Hospital \_\_\_\_\_

Name

Reason for Visit

Other: \_\_\_\_\_

Explanation

Types of Records and Release Options:

 **Vaccine Proof Records Only:**     Fax     Pick – up    Date Needed \_\_\_\_\_

Fax to Name/Facility \_\_\_\_\_ Fax # (     ) \_\_\_\_\_

 **Requesting Full Medical Records: (Pick-up or mail only)**

Pick – up (allow 48 hours)     Mail to home address above     Mail to my home new address

Pet Parents Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

In-Office Use

Approved \_\_\_\_\_ Drivers License Number \_\_\_\_\_ Copy DL \_\_\_\_\_ Called for Pick-up \_\_\_\_\_ Parent picked up \_\_\_\_\_ Mailed \_\_\_\_\_