



# Southern Ocean Animal Hospital

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Phone: (609) 296-3655 • Fax: (609) 296-8033  
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## REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM: \_\_\_\_\_ Client #: \_\_\_\_\_

I request that a copy of the medical records pertaining to my pet(s) named:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

be released to the following veterinary practice by fax, surface mail, or e-mail.

\_\_\_\_\_  
Name of Veterinary Practice

\_\_\_\_\_  
Street Address City State Zip

Phone Number of Recipient: \_\_\_\_\_

Fax Number of Recipient: \_\_\_\_\_ Number of Pages Sent: \_\_\_\_\_

E-mail Address of Recipient: \_\_\_\_\_

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