

## Request for Release of Medical Records

From:

To:

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:

VetMed Animal Health  
105 Industrial Drive, Suite 1  
Mount Juliet, TN 37122  
Phone: 615-553-4156  
Fax: 615-553-4161  
www.vetmedanimalhealth.com

Fax Number of Recipient \_\_\_\_\_ Email 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