Medical Record Release Form

Loving Hands ANIMAL HOSPITAL

Phone: (909) 591-2273
Fax: (909) 591-1178
Email: LHAHstaff@gmail.com

Date: _____

Owner: _____
Street: _____
City: _____
State: _____
Zip Code: _____
Phone: _____

Patient: _____
Breed: _____
Sex: _____
Age: _____
Color: _____

I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the animal described above, that I do hereby give, Loving Hands Animal Hospital, agents, servants, and/or representatives full and complete authority to release all medical records, vaccine records, radiographs, ultrasound photos, lab results and any other pertinent information related to the pet identified above to the following entities:

_____
_____

and I do hereby and by the presents forever release the said Doctor, his agents, servants, or representatives from any and all liability arising from said release of above mentioned items.

Signed _____