Masterson Animal Clinic

1490 Leestown Road
Lexington, KY 40511
(859)389-8387

Authorization for Release of Veterinary Medical Records

Reason for records release:

☐ Second opinion (please specify DVM): _____

☐ Vaccination certificate for boarding, grooming or obedience at:_____

☐ Change of primary care (please specify DVM):_____

Reason for changing provider: _____

I _____ the undersigned do hereby grant my permission for the release of information contained in the medical records for those patients listed below to the person or veterinary practice noted. Patient name(s) for release of medical records:

_____ _____

_____ _____

_____ _____

Check all that apply:

☐ Please fax my pet's vaccination records to: _____.

Fax number: _____

☐ Please fax my pet's medical record to: _____.

Fax number: _____

☐ I prefer to pick up my pet's (check one) records on _____.

- Vaccination
- Medical

☐ Please inactivate my chart so that I will no longer receive reminder postcards.

Owner/Client signature: _____Date:_____