Authorization to Release Veterinary Records

Please fax or email the records requested below as soon as possible to The Paws Resort & Spa. Thank you!

Email:

Fax:

Pet Parent Information:	
Name:	
Street Address:	
City:	Home Phone:
State & Zip Code:	Cell Phone:
Veterinarian Name:	
Phone:	Fax:
Email:	
Pet Information:	
Name:	Breed:
Name:	Breed:
Name:	Breed:
Name:	Breed:
Name:	Breed:
Please Include Copies Of:	
Vaccination Records ☐ Exam Reports ☐ Laboratory Reports ☐ Surgery Reports ☐	
Pathology Reports ☐ Radiology Reports ☐ Entire Medical Record ☐	

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to the Paws Resort & Spa. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

Pet Parent Signature: _____ Date: _____

Fax: 409-727-1880
Email: sdenman@thepawsresortspa.com