

## 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:**

<b>Pet Parent Information:</b>	
Name:	
Street Address:	
City:	Home Phone:
State & Zip Code:	Cell Phone:
<b>Veterinarian Name:</b>	
Phone:	Fax:
Email:	
<b>Pet Information:</b>	
Name:	Breed:
Name:	Breed:
Name:	Breed:
Name:	Breed:
Name:	Breed:
<b>Please Include Copies Of:</b>	
Vaccination Records <input type="checkbox"/> Exam Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Surgery Reports <input type="checkbox"/>	
Pathology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Entire Medical Record <input type="checkbox"/>	

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