



1745 Mileground
Morgantown,
West Virginia 26505
304 296-7387

Authorization for the Release of Medical Records

Client's Name: _____

Pet's Name: _____

Practice Name and Address that is to release pet's medical records:

I, the undersigned owner or owner's authorized agent of the pet identified above, certify that I am over 18 years of age, and hereby request that copies or summaries, as required by state law, of the medical records pertaining to the above identified pet be released to the veterinary practice or party listed below:

Name of the Recipient Practice or Party

Street Address	City	State	Zip
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Fax number of Recipient Practice or Party

Signature of Owner or Authorized Agent	Date
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Signature of Veterinarian approving this request	Date
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