Authorization to Release Veterinary Records

PLEASE FAX THE RECORDS REQUESTED BELOW TO LUCY'S AT 210-495-3649 OR EMAIL TO INFO@LUCYSDOGGYDAYCARE.COM

Client Information:

Name: ____

Address:____

City:____________________ State: ________ Zip Code:_________ Phone:______________

Pet Information:

Name: ______________________________ Breed: ___________________________
Name: ______________________________ Breed: ___________________________
Name: ______________________________ Breed: ___________________________

Please include copies of:

☐ Vaccination Records

I hereby certify that I am the owner (Client) or authorized agent of the Client 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 Lucy's Doggy Daycare and 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.

CLIENT SIGNATURE: ____________________________________ **Date:** ____________