

**Animal Health Care Center
Request for Release of Medical Records
425-203-9000**

Name of client(s) requesting a copy of medical records: _____

Address: _____

Phone: _____

Pet(s) Names: _____

Name of Veterinary Practice where my pet's records are currently held: _____

Practice Owner/ Medical Director Name: _____

Address: _____

Phone: _____

Fax & email (if known): _____

I request that copies or summaries, as required by state law, of the medical records pertaining to my animal(s) named _____

be released to:

Animal Health Care Center
504 Renton Center Way SW #3
Renton WA 98057
425-203-9000 office
425-277-0956 fax
www.ahrenton.com

I hereby authorize and provide my written consent to this transfer of medical information.

Signature of Owner or Authorized Agent

Date

Info below is intended for the sending practice. Please fill in the blanks and fax back to:

**AHCC
425-277-0956**

Please indicate below how my pets records will be sent & in what timeframe they can be expected: _____

Fax : Date & Time fax was sent: _____

Email: Senders email _____ Receivers email _____

Regular Mail: Date _____ Time _____

name of the person that prepared & sent the copies _____

Other: _____

**(As a courtesy, please fax this sheet back regardless of the sending method so we can all be informed of when the pets medical records will be arriving)

Signature of Veterinarian Who Approves This Request

Date