Veterinary Medical Records Request and Release Form

Owner Name:
____

Address:
____

City: ______________________________ State ____________ Zip code: __________________

Phone: ____

Email: ____

Patient Names:

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I authorize and request ______________________________________ to release the above patient(s) medical records to:

Park City Veterinary Clinic
2694 Huntsville Highway
Fayetteville, TN 37334
931-240-4001 (office)

Send the records via email to:

officemanager@parkcityvetclinic.com

or via FAX to: **931-291-9091**

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Owner Signature Date