



Dr. Glenda's Animal Hospital, Inc.
The Animal Hospital at Oakleaf Plantation
8483 Merchants Way
Jacksonville, FL 32222

Authorization to Release Medical Records Form

Owner Information:

Name: _____

Address: _____ Phone: _____

City: _____ State _____ : Zip Code: _____

I, certify that I am the owner or authorized agent of the pet(s) listed above, and hereby request and authorize Animal Hospital at Oakleaf Plantation to release and/or receive the requested medical information for my pet(s) per Florida Statute 474.2165, "Ownership and control of veterinary medical patient records; report or copies of records to be furnished."

Release to: _____

Email: _____ Fax # _____

Pet Information:

Pet Name _____ Breed _____

Pet Name _____ Breed _____

Pet Name _____ Breed _____

Pet Name _____ Breed _____

Please include copies of:

- | | |
|---|---|
| <input type="checkbox"/> Vaccination Records | <input type="checkbox"/> Fecal Test Records |
| <input type="checkbox"/> Heartworm Test Records | <input type="checkbox"/> Other: _____ |

Owner Signature

Date

Because Your Pet Matters