**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: __________________________________________________________________

______________________________________________________________________________

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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

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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