RELEASE OF INFORMATION CONSENT

Client Name: ______________________
Address: __________________________
____
Telephone Number: ________________

Patient Name: _____________________
Species: ___________________________

CONSENT FOR RELEASE OF MEDICAL RECORD INFORMATION

1. I give the Veterinary Health Center at Manhattan Kansas permission to release summary and/or necessary photocopies of the above-described animal's medical record from the visit(s) on the following dates of service: ____

2. I request the following specific information:

   ☐ Discharge Instructions ☐ Labs ☐ Radiology ☐ Other: ____________________________

3. Please send the information to:

   Name: _______________________________ Hospital/Clinic: _______________________________

   Address: ____

   City: ___________________________ State: ____________ Zip Code: _____________

   Phone Number: _______________________ E-Mail or Fax Number: ___________________________

4. I will use this information for

   ____ Continuous Care ____ Personal Records ____ Legal Purposes ____ Pet Insurance ____ Other ________________

5. The Veterinary Health Center at Manhattan Kansas is released from legal responsibility or liability for the release of this information sent to the above.

   Printed name of Owner/Agent: _______________________________________ Date: ___/___/___

   Signature of Owner/Agent: ____ Date: ___/___/___

Please note: If you are a veterinary clinic requesting records for a mutual patient, a Release of Information Consent must accompany the request, with a client signature.