Request for Release of Medical Records

From: _____ (pet owner)
To:_____ (holder of records, the veterinarian or hospital)

[You may print and give this form to the vet who holds your pet's records or Dr. Springer will do it for you. If Dr. Springer is submitting the form, please provide the phone number, fax, and/or email of the record holder:_____]

I request that copies or summaries, as required by state law, of the medical records pertaining to my animal(s) named _____ be released to the following veterinarian by email, fax, or surface mail:

Dr. Sandra Truli Springer, VMD
3983 Orchard Hill Circle
Palm Harbor, FL 34684

Email Address of Recipient: drtruli@VetVMD.com
Fax Number of Recipient: 877 Dr TRULI

Payment of $_____ is enclosed as payment of the fee required to photocopy and mail this information as directed. I hereby authorize and provide consent to this transfer of medical information.

_____ _____
Signature or Owner of Authorized Agent Date

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_____ _____
Signature of Veterinarian Who Approves This Request Date