LAKE COUNTRY VETERINARY CARE

Consent for Release of Medical Records

Client Name_____

Address_____

City_____State_____Zip Code_____

Phone Number(_____)_____

Pet(s) Names_____

I give my permission for the following information to be released:

Initial which one:

_____Full access of information (complete copy of history)

_____Release only Spay/Neuter, Vaccination and Heartworm History

_____Other-specify information to be released_____

_____

_____I am releasing ownership of this pet to the person or facility listed below

Please provide the required information to where the information should be sent, or who is authorized to pick up the records:

Name of Clinic, Facility or Individual_____

Address_____

City_____State_____Zip Code_____

Phone(_____)_____Fax(_____)_____

Signature of owner, agent, or authorized individual_____

Date_____

600 Hartbrook Drive, Hartland, WI 53029

Telephone (262) 369-1609 www.LakeCountryVet.com Fax (262) 369-1610