Bayport
Veterinary Hospital

Authorization to Release Veterinary Records

I, the undersigned do hereby grant my permission for the release of any or all of the information contained in the medical records of those pets listed below to Bayport Veterinary Hospital:

Please include FULL medical history (Exam notes, Radiology, Surgical, Medication, and Vaccination History)

Name of Veterinary Hospital to request records from:_____

Pet Parent Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Pet Information:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

PET PARENT SIGNATURE: _____

PLEASE FAX THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE TO BAYPORT VETERINARY HOSPITAL 631-868-7467

IF A LARGE FILE, PLEASE EMAIL TO BAYPORTVET@BAYPORTVET.COM

973 Montauk Highway, Bayport, NY 11705
631-868-7464 F-631-868-7467
Bayportvet.com