EL SEGUNDO ANIMAL HOSPITAL

AUTHORIZATION TO RELEASE VETERINARY RECORDS

To:

Phone:	Fax:

Re:

Client:	
Patient:	Dog / Cat
Patient:	Dog / Cat
Patient:	Dog / Cat

I, _____ hereby request and authorize the release of veterinary records for my pet(s) listed above, including but not limited to chart, notes, test results, referrals, consultations, diagnostic studies and imaging, records and charts of other health care providers in your posession.

Please email or fax this information to:

EL SEGUNDO ANIMAL HOSPITAL
Andrew M. Streiber, DVM
240 Center Street
El Segundo, CA 90245

email: reception@elsegundoah.com
phone: (310) 606-8811
fax: (310) 321-3446

I understand that:

I have the right to revoke this Authorization at any time by writing to El Segundo Animal Hospital.
A photocopy of this Authorization shall have the same force and effect as the original.
This Authorization is valid for 60 days from the date of execution.

Signature Date

Thank You!