



Consent to Release Medical Records

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The following form may be printed, completed, signed and then mailed to the address listed above.

Owner/Client Information:				
Name:		Date:		
Address:				
Phone:		Fax:		Email:

Pet/ Patient Information:				
Name:		Registered Name:		
Registration Number:		Birthdate:		Color:
Species:		Breed:		Sex:

Choose One or More of the options listed below.

- 1) Please send a copy of records to owner as listed above. Mail Fax Email
- 2) Please forward/transfer all medical records to the **new owner** by: Mail Fax Email

New Owner Information:				
Name:				
Address:				
Phone:		Fax:		Email:

- 3) Please forward/transfer all medical records to the following **veterinarian** by: Mail Fax Email

Veterinarian Contact Information:				
Name:				
Address:				
Phone:		Fax:		Email:

I, _____, certify that I am owner of the above described animal, and have authority to release medical records. I understand that a charge may be assessed for copies, fax and mailing at \$2.00 plus \$.25 per page. No charge will be assessed for email records.

Owner Name

Owner Signature

Date