



Authorization for Release of Veterinary Medical Records

1403 George Washington Memorial Highway
Yorktown, Virginia 23693
(757) 599-3326
www.pinemeadowvet.com
frontdesk@pinemeadowvet.com

I _____ the undersigned do hereby grant my permission to release the information contained in
(Print your name)

medical records from _____ to Pine Meadow Veterinary Hospital for the following pet(s).
(Previous Veterinary Hospital)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please release a copy of all veterinary records, including (but not limited to):

1. A detailed history for the last 2 years including vaccines, examinations, notes, radiographs/reports and laboratory diagnostics.
2. Vaccination Reminder Reports
3. Previous Medical History

Records may be emailed to frontdesk@pinemeadowvet.com or faxed to (757) 599-6034.

I authorize the release of all veterinary records.

(Must be 18 years or older) _____ Today's Date _____