P.O. Box 1029
Munford, TN 38058
(901)837-0101
fax- (901)837-0103
www.munfordanimal.com

Authorization to Release Medical Records/Information

Client Name: _____
Patients Name: _____
Client Primary Phone Number:_____

I authorize Munford Animal Hospital, LLC to release medical records or information, for _____ (patient name) owned by_____ (owner name) to the following Veterinary practice or other party, listed below, by e-mail, fax or phone.

Please specify which information is needed. A date range must be specified.

☐	Medical Records	Date range:
☐	Vaccines	Date range:
☐	Prescription history	Date range:
☐	Lab work	Date range:
☐	x-rays	Date range:

How would you like for us to send the requested records to you?
☐ E-mail _____
☐ Fax_____
☐ Phone _____

_____
Name of Practice or other party

_____
Address

I hereby authorize and provide my written consent to this transfer of medical information.

_____ _____
Signature of Owner or Authorized Agent Print name

_____
Date