Oasis Veterinary Hospital

AUTHORIZATION FOR RELEASE OF PATIENT/MEDICAL RECORDS

Owner Name: _____

Address: _____

City, State ZIP _____

Patient Name(s): _____ **Species:** _____

_____ _____

_____ _____

_____ _____

I, _____, owner or authorized agent for the owner, request and authorize _____ to copy medical information pertaining to the above-named animals' medical record(s).

Please include items below (check all that apply):

☐**Medical Record** (☐ **First to Last Visit**) (☐ **Dates: _____** to _____

☐**Diagnostic Images**

- ☐**Radiographs**
- ☐**Ultrasound Reports**

☐**Lab Reports**

- ☐**Blood work and urine results**
- ☐**Culture results**
- ☐**Biopsy/Cytology Reports**

Information to be provided to: ☐SELF

☐INDIVIDUAL/ORGANIZATION LISTED BELOW:

Individual: _____

Organization Name: _____

Address: _____

City, State ZIP _____

Telephone: 925.954.8807 **Fax:** 925.954.8635

Email: oasis@oasisveterinaryhospital.com

Signed: _____/_____

Owner or Authorized Agent Signature/ Date