



County Animal Hospital
1185 Reading Rd
Mason Ohio 45040
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(513) 459-7531 fax
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MEDICAL RECORDS RELEASE FORM

In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, "a written authorization or other form of waiver executed by the client or an appropriate court order or subpoena" is required in order for us to provide a copy of your pet's medical records.

I certify that I am the owner of the patient (s) named below or that I am acting as a legal agent for the owner.

Client's name: _____

Client's Address: _____

Client's Phone: _____

Patient Name (s): _____

By signing below, I hereby authorize County Animal Hospital to release my pet's medical records to: _____.

Client's Signature

Date