



## Annapolis Veterinary & Wellness

Phone: 410-224-6624 Website: Annapolisvet.com Email: Annapolisvet@gmail.com

### Authorization to Release Veterinary Medical Records

I, \_\_\_\_\_ (first and last name), authorize Annapolis Veterinary & Wellness to send my pets complete medical records to other veterinarians and boarding/ daycare facilities for necessary medical requirements.

#### Owner Information:

Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

#### Pet Information:

Pet Name \_\_\_\_\_ Breed: \_\_\_\_\_

Pet Name \_\_\_\_\_ Breed: \_\_\_\_\_

Pet Name \_\_\_\_\_ Breed: \_\_\_\_\_

Pet Name \_\_\_\_\_ Breed: \_\_\_\_\_

#### Records may consist of:

- Vaccination Records
- Lab Work Test Results
- Complete Medical History

I certify that I am the owner or authorized agent of the pet(s) listed above and hereby authorize Noah's Ark Veterinary & Wellness LLC, DBA Annapolis Veterinary & Wellness, its affiliates, medical staff, employees, and their representatives to release my pet(s) medical information as seen medically necessary.

Owner Name: \_\_\_\_\_

Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_