Records Release Form

I, _____, hereby give permission to Thompson Animal Medical Center to release all medical records/vaccination history (please circle one) of my pet(s) to other veterinarian clinics, kennel facilities, and groomers.*

*If you do not want your records shared with all of the listed facilities, please specify as to which facilities you are authorizing release to:

Business Name: _____
Phone Number: _____

Business Name: _____
Phone Number: _____

I certify that Thompson Animal Medical Center and its doctors are the current medical providers for this animal, and the records that they provide will be the most current and complete records available.

Signature of Owner: _____ Date:_____

Print Name: _____

Address: _____

City:_____ State:____ Zip Code: _____

Phone Number: _____