



East Bay Animal Hospital

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MEDICAL RECORD RELEASE FORM

In accordance with the Veterinary Practice Act regarding the confidentiality of a patient's medical records, a written authorization or other form of waiver executed by the client is required in order to provide a copy of your medical record.

Client Name: _____

Address: _____

Phone: _____

Patient's Name(s): _____

Reason for Request/Comments: _____

To help us continue to provide the best possible service, please be specific as to why you are requesting your pet's records. If you are transferring to a different facility and there was something we could have done differently to improve your satisfaction here, we would like to know. While we do everything we can to provide the very best in client and patient care, your feedback is often the only way we know where we may be lacking and how we can improve our service.

- I would like my pet's account inactivated. In doing so I acknowledge I will no longer receive reminders for vaccines and services due, and I will be responsible for keeping my pet up to date.

I hereby authorize East Bay Animal Hospital to release my pet's medical records to:

- Myself
 Other: _____

By signing below I certify that I am the Owner of the above mentioned patient(s), or am acting as the legal agent for the Owner.

Print Name _____

Signature: _____

Date: _____