Authorization to Release Veterinary Records
to
Pet Resort in the Gardens

PLEASE FAX THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE TO Pet Resort in the Gardens:

Attn: _____ **Fax: 817-635-5513**

Pet Owner Information:
Name: _____
Address:
_____

City: _____ State: _____ Zip Code: _____

Phone: _____

Pet Information:
Name:_____ Breed_____
Name: _____ Breed: _____
Name: _____ Breed: _____
I hereby certify that I am the owner or authorized agent of the owner of the above-described pet(s). Further, I hereby request and authorize
_____ (clinic/hospital) to release the requested medical information for my pet(s) to Pet Resort in the Gardens. I release the clinic/hospital and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

OWNER SIGNATURE: _____ Date: _____