

ALLENTOWN CAT CLINIC, P.C.

REQUEST FOR RELEASE OF MEDICAL RECORDS / INFORMATION

Client Name: _____

Client Address: _____

Phone: _____

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I request that copies of the medical records or information pertaining to my cat(s) named:

be released to:

New Practice Name or Shelter Name:

Phone Number: _____

Fax Number: _____

Client Signature

Date