Consent to Release Medical Records

Tracy R. Walker, DVM
Route 1 Box 115
Elkins, WV 26241
Phone: 304-636-8363
Fax: 304-636-7754

Owner/Client Information:

Name: _____ Date: _____
First Middle Last

Address: _____
Street/P.O. Box City State Zip

Phone: (____)_____ Fax: _(_____)_____ Email: _____

Pet/ Patient Information:

Name: _____ Registered Name: _____

Registration Number: _____ Age/Birthdate: _____

Species: ☐ Equine ☐ Bovine ☐Caprine ☐Other_____ Breed: _____

Sex: ☐ Male ☐ Female ☐ Castrate Color: _____

Choose One or More of the options listed below.

1) Please send a copy of records to owner as listed above. ☐ Mail ☐ Fax ☐ Email

2) Please forward/transfer all medical records to the **new owner** by: ☐ Mail ☐ Fax ☐ Email

Name: _____
First Middle Last

Address: _____
Street/P.O. Box City State Zip

Phone: (____)_____ Fax: _(_____)_____ Email: _____

3) Please forward/transfer all medical records to the following **veterinarian** by: ☐ Mail ☐ Fax ☐ Email

Veterinarian: _____ Clinic Name: _____
First Last

Address: _____
Street/P.O. Box City State Zip

Phone: (____)_____ Fax: _(_____)_____ Email: _____

I, _____ certify that I am owner of the above described animal, and have authority to release medical records. I understand that a charge may be assessed for copies, fax and mailing at $2.00 plus $.25 per page. No charge will be assessed for email records.

_____ _____ _____
Printed Name Signature Date