Dr. Mandy Cox, DVM
Dr. Kim Lathrup, DVM
Dr. Mandy Smith, DVM
Dr. Heather Falany, DVM
Dr. David Lavernoich, DVM

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Phone: 706-613-1880 Fax: 706-613-1844
Email: goodhandsvet@bellsouth.net

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name(s): _____ _____

_____ _____

I request and authorize _____ to release healthcare information of the pet(s) named above to:

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Medical summaries relating to the following treatment, condition, or dates: _____

_____

☐ Vaccination History

☐ Full Medical Records

Owner Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Veterinarian's Approval Signature: _____ Date Signed: _____