



MEDICAL RECORDS RELEASE & PROXY DESIGNATION FORM

Stone Ridge Veterinary Hospital

550 Center Place Drive

Rochester, NY 14615

Telephone: (585) 227-4990

Fax: (585) 227-8548

Client Name _____ Acct# _____

I give my permission for the release of any information contained in the medical records of those pets listed below, to the following person(s) or businesses:

PET NAME(S)

1. _____ 2. _____
3. _____ 4. _____

RELEASE MEDICAL RECORDS TO THE FOLLOWING PERSON(S) OR BUSINESS :

1. _____ 2. _____
3. _____ 4. _____

Date of request: _____ FAX to #(_____) _____

Reason for request of records: _____

I give permission for the following person(s) to make medical decisions and/or sign for medical procedures for my pet(s) on my behalf:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

*****This release will remain in effect until you notify us in writing of any desired changes.*****

CLIENT SIGNATURE

DATE

WITNESS SIGNATURE