

**Glenolden Animal Hospital  
405 S. MacDade Blvd.  
Glenolden, PA 19036**

**Patient Records Release Form**

Client name - \_\_\_\_\_

Client address - \_\_\_\_\_

Client Phone number - \_\_\_\_\_

Pet(s) Name(s) - \_\_\_\_\_

I, \_\_\_\_\_ am the client or authorized  
PRINT YOUR NAME

agent for the above owner. I am requesting and authorizing release of my pets' medical records for the following reasons:

\_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ALL APPLICABLE REASONS ABOVE

**Please check one:**

Please e-mail to following address: \_\_\_\_\_

I will pick records up at office. The fee is \$ 8.00 for the first 10 pages and \$ .30/page for each additional page.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

Fill out completely and fax to 610-586-5169  
Forms not filled out completely will not be processed.

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*Office use only*

Doctor's review: \_\_\_\_\_ Request filled by: \_\_\_\_\_

Office manager: \_\_\_\_\_ Form scanned: \_\_\_\_\_