



Medical Records Release Authorization

** Please allow up to 48 hours to process this request. You will be notified by email when the records have been released.*

Name: _____

Address: _____

Phone Number: _____ Email: _____

Name of your cat(s):

The information to be released includes:

- Entire Medical Record
- Current Vaccination Status Only
- Other (please specify): _____

I hereby certify that I am the owner or authorized agent of the owner of the above described cat(s). Further, I hereby request and authorize Atrium Cat Hospital to release the requested medical information for my cat(s) to the following veterinary clinic(s) and/or boarding/grooming facilities.

Facility Name: _____

Phone Number: _____

Email Address: _____

I release Atrium Cat Hospital and its staff from any and all legal liability for the release of information to the extent indicated and authorized herein. I may revoke this authorization in writing at any time.

Signature: _____ Date: _____