ANIMAL HOSPITAL AT STEINER RANCH

5145 Ranch Road 620 North, Suite F-140
Austin, Texas 78732
Phone 512-900-2728
FAX 512-900-2729
staff@steinervet.com

RECORDS RELEASE AUTHORIZATION

Prior or alternate veterinarian/clinic name: ______________________________________

Prior veterinarian street address (if known): ______________________________________

Prior veterinarian city, state, ZIP (if known): ______________________________________

Prior veterinarian phone number (if known): ______________________________________

Prior veterinarian fax number (if known): ______________________________________

Prior veterinarian email address (if known): ______________________________________

By signing below, I authorize the immediate sharing of all medical records pertaining to my **pet(s) named**:

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

with The Animal Hospital at Steiner Ranch, ***including the full history of vaccinations, examination notes, diagnostic or screening tests and results, radiographs, medications prescribed and administered, diagnoses, treatments, and all other veterinary patient records required to be maintained and shared at the animal owner's direction by Rule 573.52 of the Texas Administrative Code, Title 22, Part 24 of the Veterinary Practice Act.***

These records should be emailed to **staff@steinervet.com** (preferred) or faxed to (512) 900-2729.

I also authorize The Animal Hospital at Steiner Ranch to transmit (as needed) records for my pet(s) at the request of any boarders, groomers, veterinarians, or other pet service providers acting on my/our behalf.

Primary Pet Owner's Name (Printed): ____

Primary Owner Signature: ________________________________ Date: ____________

Other Pet Owner (if applicable): ____

Other Pet Owner Signature: ________________________________ Date: ____________