



# 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): \_\_\_\_\_

I authorize the immediate sharing of all medical records for the following pets with The Animal Hospital at Steiner Ranch:

Pet 1: \_\_\_\_\_ Pet 3: \_\_\_\_\_

Pet 2: \_\_\_\_\_ Pet 4: \_\_\_\_\_

***Texas practitioners: This includes the full history of vaccinations, exam notes, diagnostic or screening tests and results, radiographs, medications prescribed and administered, diagnoses, treatments, and all other patient records required to be maintained and shared at the animal owner's direction per Rule 573.52 of the Texas Administrative Code, Title 22, Part 24 of the Veterinary Practice Act.***

Records should be emailed to [staff@steinervet.com](mailto:staff@steinervet.com) (preferred) or faxed to (512) 900-2729. If faxed, please feed head-first so records arrive electronically in a readable orientation (we do not print out).

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: \_\_\_\_\_

Additional Pet Owner (if applicable): \_\_\_\_\_

Additional Pet Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_