**RECORDS RELEASE AUTHORIZATION**

***(Please fill out the shaded areas. You may do this electronically and then save the document and e-mail to us, or print the form out and fill out by hand. Use multiple forms if your pet has been under the care of multiple health care providers in the past three years.)***

***PRIOR VETERINARIAN INFORMATION***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Clinic or Hospital (Facility) Name** | | | **Primary Veterinarian Name** | | | |
|  | | |  | | | |
| **Street Address (if known)** | | **Clinic City** | | **State** | | **ZIP Code (if known)** |
|  | |  | |  | |  |
| **Phone Number (if known)** | **Clinic E-Mail (if known)** | | | | **Clinic Fax (if known)** | |
|  |  | | | |  | |

**Pet Owner Affidavit**

By either written or electronic signature(s) at the bottom of this form, I/we authorize the immediate sharing of all medical records for the following pets with Animal Hospital at Steiner Ranch:

|  |  |  |  |
| --- | --- | --- | --- |
| **Pet 1 Name** | **Pet 2 Name** | **Pet 3 Name** | **Pet 4 Name** |
|  |  |  |  |

***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. We appreciate your assistance in providing the best possible care.***

***Out-of-State Practitioners: Please provide as complete a record as possible, in accordance with your jurisdiction’s requirements, to aid this pet owner in making the transition of their pet’s care.***

E-Mail records to [**staff@steinervet.com**](mailto:staff@steinervet.com) (preferred). If they must be faxed, please feed pages head-first so they arrive electronically in proper orientation (we do not print faxes out). Our fax number is (512) 900-2729.

I also authorize 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.

|  |  |  |
| --- | --- | --- |
| **Pet Owner Printed/Typed Name** |  | **Co-Owner Printed/Typed Name, if available** |
|  |  |  |
| **Pet Owner Signature**  ***(Type for Electronic; Print Out & Sign for Written)*** |  | **Co-Owner Signature, if available**  ***(Type for Electronic; Print Out & Sign for Written)*** |
|  |  |  |