

## **Medical Records Release Authorization**

I, \_\_\_\_\_\_ certify that I am the owner or authorized agent of the pet(s) stated below. Further, I hereby request and authorize the release of medical records (including: laboratory results, vaccination records, exam reports, surgical and anesthesia records, pathology reports and radiographs) of my pet(s). Forward my records to the Waverley Animal Hospital.

Pet(s) Name

Signature	Date	
2400 Waverley Rd, Waverley, NS t. 902.576.2068 f. 902.576.2103	B2R 1Z1 e. careteam@waverleyanimalhosp	bital.ca

Dr. Pauline Giffin 🗳 Dr. Krista Simonson