

## Request for Release of Medical Records

**TO:** Animal Health Clinic of Funkstown  
PO Box 669  
26 East Baltimore Street  
Funkstown MD 21734

I hereby request that a copy of the medical records of my animal (s) named:

\_\_\_\_\_ be released to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Fax : \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature