Kohimarama Veterinary Clinic Limited

Owner's Consent for Release of Medical Records.

325 Kohimarama Road
Auckland 1071

Ph: (09) 5211457
Fax:(09) 5289144

Your Details:

Name: ……
Address: ……
……
……
Contact Phone Number: ……..
Current Veterinarian: **……**

Person to whom records are to be released:

Name: ……..
Full Postal Address: ……..
Phone Number: ……..
Fax Number: ……..

Animal Details

1. Name: …… Breed: …… Sex: ……
2. Name: …… Breed: …… Sex: ……
3. Name: …… Breed: ……... Sex: ……

Declaration:

I declare that I am the owner of the aforementioned animals and hereby authorise Kohimarama Veterinary Clinic Ltd. to release their medical records to the person named above.

Signed ……. Date:……

Office Use Only

Client Number: ……..
Patient Numbers: …….. …… ……..