Wellness Waggin'
ACUPUNCTURE
Healing Pets in the Comfort of Home

404.579.7806 • **www.wellwag.com**

Authorization to Release Veterinary Records

PLEASE EMAIL THE RECORDS REQUESTED BELOW AS SOON AS POSSIBLE TO WELLNESS WAGGIN' AS NOTED BELOW:

Attn: Dr. Mitzi Schepps **Email:** vet@wellwag.com

Pet Parent Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Pet Information:

Name: _____ Breed: _____
Name: _____ Breed: _____
Name: _____ Breed: _____

Please include copies of:

☐ Vaccination Records ☐ Laboratory Reports ☐ Exam Reports ☐ Surgery Reports
☐ Pathology/Biopsy Reports ☐ Radiology/X-Ray Reports ☐ Entire Medical Record _____
(*Date Range*)

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to Wellness Waggin' and its successors. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein.This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

PET PARENT SIGNATURE: _____ **Date:** _____