

## **AUTHORIZATION FOR RELEASE OF INFORMATION**

<affix client="" here="" label=""></affix>		Provide	r: Excelsior Animal Hospital Inc. 130 Oak Street Excelsior, MN 55331 (952) 474-1106	
Email:		_		
This authorizati	on form will apply	y to all pets in th	e above labeled household.	
	my cancellation w	vill take effect wh	until Annual Physical Exam is repeated nen the provider receives my notice in writ ow to the requester(s).	ing.
Information to be disclosed: (Medic ☐ Entire Medical Record OR	al Record Release	e)		
☐ Lab Reports ONLY (This in Vaccination Dates ONLY ☐ NONE			ng facilities)	
Requested by: (To whom can the in  Other Veterinary Clinics  Boarding Facilities  Grooming Facilities				
☐ City Offices ☐ Rescue/Adoption Agencies ☐ NONE	s/Other			
G• .	<b>D</b> 4	Keep current selections?		
Signature	Date	Yes	<b>No: Corrections Below</b>	