DAY HOLLOW ANIMAL HOSPITAL

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Records Release

Date: _____

I hereby request in writing a copy of the medical record(s) for my pet(s) named:

_____

☐ I request this copy of the medical record in the following format (choose one only):

- o _____PDF file to be delivered to my e-mail address:_____
- o _____CD/DVD to be picked up at Day Hollow Animal Hospital
- o _____Paper copy of medical record to be picked up at Day Hollow Animal Hospital

☐ I request this medical record be mailed to my home address (except PDF file):

- o _____

I understand that this medical record is my property and it is my responsibility to provide a copy to anyone that I choose. I understand that the hospital will provide the record for the last two years (vaccine history, diagnoses, problem summary, medications, and products dispensed) at no cost as long as it is picked up at Day Hollow Animal Hospital or e-mailed to me as a PDF file. Repeat request for the same record will incur a fee of $.50 per page. I may request the entire medical record to be provided at a cost of $.50 per page (may vary from 5 to 100 pages per pet). If the copy of the medical record is delivered through the postal service and is more than 10 pages in length, there is a $10.00 postage/handling fee. The requested copy of the medical record will be available within 2 business days. If my pet has an emergency and I need records immediately, the cost is $1.00 per page and they will be faxed, e-mailed, or ready for me to pick-up within the same business day. Payment is expected at the time records are released.

Signature of Client or Co-Owner: _____
Contact Phone number of Client or Co-Owner_____