CORNELL UNIVERSITY HOSPITAL for ANIMALS

MEDICAL RECORDS DEPARTMENT

AUTHORIZATION FOR RELEASE OF PATIENT/MEDICAL RECORDS

Owner: _____

Address: _____

_____

Patient Name: _____ Species: _____ Med. Rec.#: _____

I, the undersigned, owner or authorized agent for the owner, of the above described animal, authorize Cornell University Hospital for Animals to copy medical information pertaining to the above-named animals' medical record.

Signed: _____
Owner Signature Date

Signed: _____
Authorized Agent Signature Date

Signed: _____
Authority to Sign Date

Check all that apply:

- ☐ Medical Record (Or dates of _____ through _____)
- ☐ Diagnostic Images Only
  - o Radiographs
  - o Sonograms
  - o CT Scans
  - o Scintigrams
- ☐ Lab Reports Only
- ☐ Discharge Statement Only

Information to be provided to: ☐ SELF OR ☐ INDIVIDUAL/ORGANIZATION LISTED BELOW
(PLEASE PRINT CLEARLY)
Name: _____
Organization: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Fax: _____

Please return signed and completed form via fax to (607) 253-3293
Or mail to: Cornell University Hospital for Animals, Medical Records VMC Box 35, Ithaca, NY 14853

ORIGINAL – Medical Record

XC – Imaging Folder and Service Clinican (RadiologyOnly)

Revised 4/30/09