Permission to Release Medical Records *to* Wilmington Animal Hospital

I, (name)_____ of (address: street, city, state)

_____,

give (name of veterinary practice)_____ permission to release

or discuss all records for the following pets:

To:
(Name of veterinarian if known) _____
Wilmington Animal Hospital
828 Philadelphia Pike
Wilmington, DE 19809
Fax: (302)762-1620
Email: reception@wilmingtonanimalhospital.com

Signature: _____

Date: _____