



MEDICAL RECORDS DEPARTMENT
AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Owner Name: _____

Patient Name: _____ Species: _____ Case # _____

Address: _____ City: _____ ZIP: _____

I authorize Cornell University Hospital for Animals to release the above named patient medical records to:

Form with fields: Name, Address, City/State/Zip Code, (Area Code) Phone, (Area Code) Fax

Description of information that may be disclosed:

- Checkboxes for: Dates of service From: Through: Laboratory Results Imaging Reports (Radiographs, US, CT, MRI, NM) Imaging Studies on a CD (Radiographs, US, CT, MRI, NM) Entire Medical Record

The information will be used/disclosed for the following purposes:

- Checkboxes for: Continuity/Transfer of Care Legal Insurance/Payment of Bills Other: _____

I understand that by authorizing Cornell University Hospital for Animals, to use/disclose the information, that they may receive compensation for reasonable expenses incurred for making photo copies of medical records.

I understand that I may revoke this authorization in writing at any time by contacting the medical record department, except to the extent that action has been taken in reliance on this authorization. This authorization expires _____ (insert applicable date or event), on or within (6) months or the date of the authorization, whichever is greater.

Owner Signature: _____ Date: _____

Please return signed and completed form via fax to (607) 253-3293, email to vet-medrec@cornell.edu, Mail to Cornell University Hospital for Animals, Medical records VMC Box 35, Ithaca, NY 14853.

