**MEDICAL RECORDS DEPARTMENT**
**AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS**

Owner Name: ____________________________

Patient Name: ____________________________Species: ____________________ Case #_________________

Address: ________________________________ City: __________________ State: _______ZIP: ___________

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

| Name: | |
|---|---|
| Address: | |
| City/State/Zip Code: | |
| (Area Code) Phone: | (Area Code) Fax: |
| Email Address: | |

Description of information that may be disclosed:

- ☐ 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:

- ☐ 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.