Thompson Veterinary Clinic Medical Records Release Form

To comply with the American Veterinary Medical Association's Principles of veterinary medical ethics regarding medical records, the Thompson Veterinary Clinic requires written consent by the owner to release summaries or copies of their pet's medical records to another veterinary practice or interested party.

To facilitate this process, the Thompson Veterinary Clinic requires that you please use this Medical Records Release Form when requesting summaries or copies of your pet's medical records. The completed and signed form can be mailed, faxed to the Thompson Veterinary Clinic (906-341-3595) or photographed and emailed(info@thompsonvetclinic.com).

Digital medical record summaries will be emailed to you or to the veterinary practice of your choice at no charge. Digital medical record summaries will be emailed within 2 business days upon receipt of the signed form.

Photocopies or facsimiles of the patient's written medical records will require a processing fee of $15 and a processing period of 5 business days upon receipt of the signed form and payment. Copies of the written medical records can be mailed or faxed, but not emailed.

From: _____ (party requesting a copy of medical records)

Phone number to reach you at if questions? _____

To: Thompson Veterinary Clinic, 440 Chippewa Ave, Manistique, MI 49854

I request that copies of written records ($15 charge) ☐ or digital summaries (No Charge) ☐, as required by state law, of the medical records pertaining to my animal(s) named be released to the following veterinary practice or other party by fax or surface mail or by email:

Name(s) of Animals:_____

Name of Practice or Other Party:_____

Street Address City State Zip:_____

Fax Number of Recipient _____

Email address of Recipient _____

Payment of the $15 fee is required to photocopy and mail or Fax copies of the written medical records. You may either enclosed this form and payment and return via mail or pay over the phone and email form back. I hereby authorize and provide my written consent to this transfer of medical information.

_____ _____

Signature of Owner or Authorized Agent Date