College of
Veterinary Medicine
UNIVERSITY *of* FLORIDA

THE PET LEGACY PROGRAM
VETERINARY RECORD RELEASE FORM
Attachment B

Owner Name:____

Address: ____

____

City:________________________State:_______Zip Code:_______________________

Veterinarian Name:____

Address: ____

____

City:________________________State:_______Zip Code:_______________________

Telephone:____________________________Fax:_________________________________

Email:________________________________

Dear Dr:______________________________,

I/We authorize you to release to the University of Florida, College of Veterinary Medicine Pet Legacy Program, the complete medical records of my pet(s) upon their written request and at their expense. This consent shall remain in effect until and unless I notify you otherwise in writing.

Sincerely,

____
Owner