



**Authorization for Release of Records to Colonie Animal Hospital**

I, \_\_\_\_\_, the owner of \_\_\_\_\_  
Name (s) of pet (s)

Hereby authorize \_\_\_\_\_ to provide Colonie  
(Name of Veterinary Hospital)

Animal Hospital photocopies/fax/digital copies of all medical records  
pertaining to the above named pet(s).

Owner's signature \_\_\_\_\_ Date \_\_\_\_\_

Please Send or Fax To:

*COLONIE ANIMAL HOSPITAL*

*1946 Central Avenue*

*Albany, NY 12205*

*Phone (518) 456-1613*

*Fax (518) 4560917*