



Dr. Mandy Cox, DVM  
Dr. Kim Lathrup, DVM  
Dr. Shannon Jones, DVM  
Dr. Heather Falany, DVM  
Dr. David Lavernoich, DVM

---

2391 Daniels Bridge Rd., Athens, GA 30606

Phone: 706-613-1880 Fax: 706-613-1844

Email: goodhandsvet@bellsouth.net

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name(s): \_\_\_\_\_  
\_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the pet(s) named above to:

Practice  
Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Medical summaries relating to the following treatment, condition, or dates: \_\_\_\_\_  
\_\_\_\_\_

Vaccination History

Full Medical Records

Owner Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Veterinarian's  
Approval  
Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_