

THE EQUINE CLINIC AT OAKENCROFT

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Release of Medical Records

I _____ hereby release all medical records pertaining to the horse _____ to the person(s) specified below. I understand that this includes exam findings, treatments, vaccinations, and any imaging studies including but not limited to radiographs, ultrasounds, thermographic images and the interpretations of those studies. The medical records will be released solely to the below named and to no other persons. The Equine Clinic at OakenCroft may not be held liable for any actions taken by any parties pertaining to the release of these records to the person or persons named below.

Name:	_____
Address:	_____

Phone:	_____
Email:	_____

Name:	_____
Address:	_____

Phone:	_____
Email:	_____

Signature: _____ **Date:** _____

Name (Printed): _____