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Syracuse Equine
VETERINARY SPECIALISTS

AUTHORIZATION FOR USE/DISCLOSURE OF MEDICAL RECORDS

Client Name: _____
Last First Middle

Horse(s) Registered Name(s): _____

_____

Client's Email Address: _____

I authorize Syracuse Equine Veterinary Specialists, PLLC to release confidential medical records electronically to the recipient that I have identified below. Note: Please allow 10-14 days for completion of the request.

Recipient:

Full Name: _____

Email address: _____

Information to be disclosed*:

A specific medical record (include date and type):

_____

_____

□ All of my patient medical records that SEVS has in its possession, not including imaging (radiographs, ultrasound, etc)

□ All of my patient medical records that SEVS has in its possession, including imaging

_____ _____ _____
Signature Printed Name Date