



MEDICAL RECORDS RELEASE AUTHORIZATION

Pet Owner's Name: _____ Phone: _____

Address: _____

I have released my animal(s) to MaxFund.

I authorize name of veterinary practice or veterinarian: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

to release all medical records to the staff of MaxFund.

Owner's Signature: _____ Date: _____

PET INFORMATION

NAME DOG/CAT BREED SEX AGE

Pet #1					
Pet #2					
Pet #3					
Pet #4					