Transfer of Records Request Form

_____
Animal Hospital Name

_____
Street address

_____
City, State & Zip

_____
Phone number

_____
Fax number

To whom it may concern

I would like to kindly request the release of all our pets records to the

Animal Hospital of Cold Spring
55 Chestnut St.
Cold Spring NY 10516
Phone (845) 265 4366
or (845) 265 - PETS (7387)
Fax (845) 507 1100

We would like to request that they be received there by _____

(Pet names)

_____ _____
Name

_____ _____
Street address

_____ _____
City, State & Zip

_____ _____
Phone number

_____ _____
Signature Date