



# *Animal Clinic of Santa Maria*

2650 SOUTH MILLER ST 805 937 7671

## Medical Record Request Form

PLEASE FILL OUT THIS REQUEST FORM AND SEND TO THE HOSPITAL THAT HAS YOUR PET'S MEDICAL RECORDS. PLEASE ALLOW AMPLE TIME FOR THE REQUEST TO BE COMPLETED.

CLIENT'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_

PET NAME(S) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CLIENT'S PHONE  HOME \_\_\_\_\_  WORK \_\_\_\_\_  CELL \_\_\_\_\_

PLEASE RELEASE MY PET'S MEDICAL RECORDS.

PLEASE FAX THE RECORDS TO: ANIMAL CLINIC OF SANTA MARIA  
FAX (805) 934-8361

PLEASE MAIL MY RECORDS TO: ANIMAL CLINIC OF SANTA MARIA  
2650 SOUTH MILLER STREET  
SANTA MARIA, CA 93455

I WOULD LIKE TO PICK UP A COPY OF MY PET'S RECORDS

CLIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_