West Side Pet Clinic
1245 Niagara Street
Buffalo, N.Y. 14216

T: (716) 882-1245
F: (716) 931-9837

E: wspcbuffalo@gmail.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

HUMAN'S NAME: ______________________________

ADDRESS: ______________________________

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PHONE: ______________________________

PET'S NAME: ________________ **DATE OF BIRTH:** __________

SPECIES: CAT DOG OTHER

I certify that I am the human companion of the animal listed above. I hereby authorize West Side Pet Clinic to discuss my pet's medical treatment and any financial transactions associated therewith, with the following limitations:

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with the following person or corporate entity:

NAME: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________

This authorization will expire on ________________ unless earlier revoked.

SIGNATURE: ______________________________

DATE: ______________________________