



551 E. Maple Rd. | Troy, MI 48083 | Ph: 248.250.9838

Authorization to Release Veterinary Records

Please email or fax the records requested to:

Email: information@k9club.com

Fax: (248)928-5129

Pet Parent Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Pet Information

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

Please include copies of:

- Vaccination records Laboratory reports Exam reports Surgery reports
- Pathology/Biopsy reports Radiology/X-ray reports Entire medical record

K9 Club requires the following vaccinations:

- FeLV (Feline leukemia virus)
- FVRCP (Feline distemper)
- Rabies

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s).

I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) to K9 Club

Pet Parent Signature: _____ **Date:** _____