



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

Authorization to Release Veterinary Records

Please fax or email the records requested to:

Email: information@k9club.com

Fax: (248)928-5129

Pet Parent Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Your Dog's Information

Name: _____ Breed: _____

Please include copies of the following vaccination records:

- Rabies - 1 or 3 year
- DHPP
- Leptospirosis
- Bordetella - required every 6 months and at a minimum of 10 days prior to check-in
- Canine Influenza - 2 initial doses, 2 - 4 weeks apart; administer a single dose within 1 year following completion of the initial 2-dose series, then every year thereafter
- Fecal exam - required every 12 months

Additionally, please include copies of the following records:

- Pathology / biopsy reports
- Laboratory reports
- Radiology / x-ray reports
- Exam reports
- Surgery reports

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 dog to K9 Club.

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