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 annually 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 12months

Additionally, please include copies of the following records:

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

Veterinary Information

Name:_____Phone Number: _____

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: _____