Medical Records Request Form

This form is to request copies of medical records. Only clients or their legal representatives may make a medical record request. Memorial-610 Hospital for Animals may verify your identity. Some requests may be subject to a reasonable fee.

Client Name: _____

Patient Name: _____ Species: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Description of information requested (mark all that apply):

- ☐ Dates of Service: From _____ Through _____
- ☐ Laboratory Results
- ☐ Imaging Reports/Studies (Radiographs, US, CT, MRI)
- ☐ Entire Medical Record

Purpose of Disclosure (select one):

- ○ Treatment/Continuing Medical Care
- ○ Insurance Claims/Payment of Bills
- ○ Legal
- ○ Other: _____

I want to request medical records to be sent to the third-party I have indicated below. My completion of this form serves as authorization for Memorial-610 Hospital for Animals to disclose these records to this person or group. I understand that once my information leaves Memorial-610 Hospital for Animals, Memorial-610 Hospital for Animals is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Fax: _____ Email: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action had already been taken in reliance on this authorization.

This authorization expires _____ (insert applicable date or event),

on or within 180 days or the date of authorization, whichever is greater.

Signature: _____ Date: _____

Mail or deliver completed forms to:
Memorial-610 Hospital for Animals
910 Antoine Drive
Houston, TX 77024
Fax: 713-682-6359
Email: mem610@mem610.com