CityU 香港城市大學 City University of Hong Kong
VMC Veterinary Medical Centre
Welfare of the animal comes first and last

CityU Veterinary Medical Centre 城大動物醫療中心
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MEDICAL RECORDS DEPARTMENT
AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Owner Name: _____ Contact #: _____

Patient Name: _____ Breed: _____ Client #: _____

Address: _____

I authorize CityU Veterinary Medical Centre (VMC) to release the above-named patient medical records to:

Name of Clinic:	Contact #:	Fax #:
Address:	Email Address:	

Description of information that may be disclosed:

☐ Dates of service From: _____ Through: _____

The information will be used/disclosed for the following purposes:

☐ Continuity / Transfer of Care
☐ Others: _____

I understand that:

- By authorizing CityU Veterinary Medical Centre (VMC), to disclose the information, CityU Veterinary Medical Centre (VMC) will only fax or email to the receiving veterinary clinic.
- A fee of $160 will be incurred by owner to CityU Veterinary Medical Centre (VMC) for photocopies of medical records.
- Medical records will not be released until this form is signed by owner (or authorized person) and received by CityU Veterinary Medical Centre (VMC) or verbal consent is verified by a second individual.

Owner Signature: _____ Date: _____
(or Authorized Person)

Please return signed and completed form
via fax to (852) 2715 3490,
via email to info@cityuvmc.com.hk,