Brandon
Equine Medical Center
Experience. Details. Results.

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS

Owner: _____

Address: _____

_____

Patient/Horse Name: _____

I, the undersigned, owner or authorized agent for the owner, of the above named horse, authorize Brandon Equine Medical Center to release the horse's medical records to:

_____

Signed: _____
Owner Signature Date

Signed: _____
Authorized Agent Signature Date

Please return signed and completed via:
Fax: 813-643-5877
Email: office@brandonequine.com
Mail: Brandon Equine Medical Center, 605 E Bloomingdale Ave, Brandon FL 33511