CENTRAL PASCO VETERINARY CARE

17945 STATE ROAD 54
LUTZ, FL 33558
PH: 813-926-1126
FAX: 813-926-5264

MEDICAL RECORD REQUEST FORM

Date: _____

Parents Name(s): _____

Patient Name(s): _____

Address: _____

Phone: ( ) _____ **Email:** _____

Reason for Request: ☐ Relocation: _____
New Address
_____

Veterinary Facility: ☐ Specialist: _____
Name
_____
Reason for Visit

☐ Family Veterinary Hospital: _____
Name
_____
Reason for Visit

☐ Other: _____
Explanation

Requesting Full Medical Records: (Please allow 48 hours for processing)

Options: ☐ Pick – up ☐ Mail to current address above ☐ Mail to my new address listed

Pet Parents Signature: _____

Printed Name: _____ **Date**: _____

In-Office Use (Initial)

Driver's License Number _____ **Copy DL of file:** _____ **Approved**_____

Called for Pick-up_____ **Parent picked up**_____ **Mailed**_____ **Marked in Avimark:** _____