

# Release of Case Information Authorization Form

Washington Animal Disease Diagnostic Laboratory  
College of Veterinary Medicine, Washington State University

USPS address:  
P.O. Box 647034  
Pullman, WA. 99165-7034  
Phone: (509) 335-9696  
FAX: (509) 335-7424

Please type or use black ink and print clearly.

Veterinarian or Case Coordinator:		
Clinic:		
Street:		
City:	State:	Zip:
Phone:	Fax:	

Owner:		
Street:		
City:	State:	Zip:
Phone:	Fax/E-mail:	

RE: WADDL Case Number \_\_\_\_\_

I authorize the release of information pertaining to the WADDL Case number above to the following person(s) or entity(ies) listed below:

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NOTE: Authorization may be given by the animal Owner OR the Veterinaria of record, as appropriate for each case. Signatures are not needed from both.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Owner's Signature

\_\_\_\_\_  
Date

**OR**

\_\_\_\_\_  
Veterinarian's Signature

\_\_\_\_\_  
Date