

AUTHORIZATION TO RELEASE RECORDS

As the owner of the following animal(s), I AUTHORIZE release of records, from the facility indicated below, pertaining to the animal(s) listed below to the Washington Animal Disease Diagnostic Laboratory (WADDL).

Animal Name(s) or ID number(s):

Clinic or other Facility for Records Release Request:

Name: _____

Veterinarian: _____

Address: _____

City _____ State _____ Zip Code _____

Phone: _____ FAX: _____

Owner Name (please print)

Signature of Owner

Date