



Primary Veterinary Medical Records Release Form

Name: _____

Dog's Name: _____

Primary Veterinary Provider (Name, Address, Phone #):

I, the undersigned do hereby grant my permission for the release of any or all of the information contained in the medical records of my dog, _____, to Save a dogslife ("dogslife"), a Texas nonprofit corporation and 501(c)(3) tax-exempt organization, via email at dogslifeorg@gmail.com.

I understand that dogslife provides grants to assist program beneficiaries with dogs under a treatment plan for cancer and that medical records for my dog, whose treatment I am applying for financial assistance through dogslife, must be provided by my dog's primary veterinarian in order for my application to be considered.

I understand that neither my authorization of the release of my dog's medical records, nor the veterinarian's subsequent release of my dog's medical records, in any way, indicates that my application for assistance has been accepted by dogslife or that dogslife will provide any financial assistance for my dog's treatment.

(print)

(sign)

(date)

Representative of dogslife:

(print)

(sign)

(date)