Lynden Police Department

AUTHORIZATION FOR RELEASE OF ANIMAL INFORMATION

PATIENT INFORMATION:

_____ DOB: _____ _____

(**PRINT** name of animal) (Breed of Animal)

OWNER INFORMATION:

_____

(**PRINT** Name)

_____

Current Address

INFORMATION TO BE RELEASED FROM: _____

Name of designated Facility or Provider

_____

Address

INFORMATION TO BE SENT TO:

LYNDEN POLICE DEPARTMENT
ANIMAL CONTROL DIVISION
203 19TH STREET
LYNDEN, WA 98264
(360)354-2828 FAX (360) 354-7609

INFORMATION TO BE RELEASED:

☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests).

☐ All medical records

☐ Specific information (Please specify treatment date or type): _____

_____

MY RIGHTS:

I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ **DATE:** _____

(Owner or Authorized Representative)

This authorization will expire 90 days from the date signed.

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Lynden, Washington 98264
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