



**AUTHORIZATION TO RELEASE IMAGES**

I authorize the New Bolton Center at the University of Pennsylvania to release my images regarding my animal.

_____	_____
Owner Last Name	Case Number
_____	_____
	Animal Name

Please release my animal's images information to:

Myself

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

New Bolton Center, its employees and officers, and the attending clinician are released from legal responsibility or liability for the release of this information to extent indicated and authorized herein.

_____	_____
Owner's Signature	Date

If you have any questions, you may contact the Medical Records Department at (610) 925-6108 or [vet-records@vet.upenn.edu](mailto:vet-records@vet.upenn.edu).