ARROWHEAD
VETERINARY CENTRE

Medical Record Transfer Request

Date: _____

Client Name: _____

Telephone Number: _____

Pet(s) Name: _____

Vet Clinic Name: _____

I consent to have my pet(s) medical records transferred to Arrowhead Veterinary Centre.

Please send the requested records to them via e-mail or fax.

Email: arrow70@shaw.ca

Fax: 403-932-4695

_____

Client/Authorized Agent Signature