County of San Diego

DANIEL E. DESOUSA, CAWA
DIRECTOR

DEPARTMENT OF ANIMAL SERVICES
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT'S NAME:_______________________________

PATIENT'S DOB:_______________________________

PATIENT'S SSN:_______________________________

DATE OF INCIDENT:_______________________________

DOG OWNER''S NAME:_______________________________

ACTIVITY NUMBER:_______________________________

DOG BITE NUMBER:_______________________________

I, _______________________________________, hereby authorize
print patient's name

____
print name and address of medical provider

to release to the County of San Diego Department of Animal Services all of my medical records that are related to the dog bite and/or attack listed above. I also acknowledge that the Department may release these medical records to the dog owner.

____
PATIENT'S SIGNATURE

____
DATE *

PHOTOCOPIES OF THIS AUTHORIZATION MAY BE USED AS ORIGINALS

* THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER THIS DATE