



County of San Diego

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CARLSBAD, CA 92011-1531
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

5821 SWEETWATER RD.
BONITA, CA 91902-2219
619.767.2675
FAX 619.470.9155

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