Fairfield Animal Hospital
1126 Village Plaza
Columbiana, OH 44408

Authorized Agent Form

8/7/2023

Please fill out the information below and return to the staff.

PRIMARY OWNER(S) INFORMATION

Name: _____ _____
(first) (last)

And/Or _____ _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone # _____ Additional # _____
(__ cell or __ landline) (__ cell or __ landline)

Do you give permission to text to these numbers? ____Yes ____No

AUTHORIZED AGENTS

This is anyone who who you concent to making discussing your pet(s) care and can make decisions about your pets. If not listed, we cannot legally provide any information, fill medications, or answer questions about your pet. Please list any parents, children, friends who may concent to treatment or may call about your pet.

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

BOARDING/GROOMING

☐ I consent to releasing information(vaccine records, medical records, or information about your pet(s)) to ANY grooming and/or boarding and/or day care institues.

☐ I consent to releasing information only to the provided place(s)

_____

☐ I **DO NOT** consent to releasing information(vaccine records, medical records, or information about your pet(s)) to grooming and/or boarding and/or day care institues.

RESCUES

☐ I consent to releasing information(vaccine records, medical records, or information about your pet(s)) to rescues/humane societies, etc.

☐ I consent to releasing information only to the provided place(s)

_____

☐ I **DO NOT** consent to releasing information(vaccine records, medical records, or information about your pet(s)) to rescues/humane societies, etc.

_____

Owner Date