VINEYARD VETERINARY HOSPITAL
EXCLUSIVELY DEDICATED TO DOGS AND CATS

CLIENT INFORMATION

Last Name:_____ First Name:_____ Spouse/ Co-Owner _____

Address_____City_____State_____Zip_____

Main Contact Number (_____)_____ Alternate Number (_____)_____

Spouse/ Co-Owner Number (_____)_____

Email Address:_____ Owner DOB:_____/_____/_____
(DEA requirement for any controlled substance dispensed to pet)

Emergency Contact Name:_____ Emergency Contact Number:(_____)_____

Recommended by:_____

I authorize Vineyard Veterinary Hospital to render any treatment that is deemed necessary to my pet's health while in custody of the hospital. I understand that in the event of any unusual or emergency circumstances, the staff will make every attempt to contact me or my designated representative before proceeding with treatment, if time permits. I understand that there is no guarantee of successful treatment and that no such guarantee has been made or offered.

*Should my pet require hospitalization, I agree to pick up my animal when he/she is ready for release. Failure to retrieve my animal within 5 (five) days of notification that he/she is ready for release will deem the pet abandoned and require Vineyard Veterinary Hospital to handle the animal in accordance with the California Abandoned Animal Act. Abandonment of an animal does not release the owner/ agent of financial responsibility for that animal. **I understand that a deposit is required on all pets admitted to the hospital. I obligate myself to pay all fees incurred at time services are rendered.** I understand that **Vineyard Veterinary Hospital does not offer billing**.*

I certify that I am at least 18 (eighteen) years of age and that I am the owner or owner's agent and am duly authorized to execute the above and accept its terms.

Signature of Owner/Agent: _____ Date: _____/_____/_____

Authorization to Provide Medical Records to a Third Party

I authorize Vineyard Veterinary Hospital to release copies of my pet's medical records to a third party, only at my explicit request. I understand and agree that all medical records pertaining to my pet will be treated with the utmost confidentiality under doctor/patient privilege unless I explicitly instruct Vineyard Veterinary Hospital to disclose specific information to a third party.

I am aware that according to California Business and Professions Code 4857, nothing in this section is intended to prevent the sharing of veterinary medical information between veterinarians and peace officers, humane society officers, or animal control officers who are acting to protect the welfare of animals.

By providing my signature below, I acknowledge that I have read and understood the terms of this authorization, including the provision regarding the sharing of veterinary medical information as permitted by California law, and I consent to the release of my pet's medical records in accordance with the specified conditions.

Signature of Owner/Agent: _____ Date: _____/_____/_____