East Orlando
ANIMAL HOSPITAL

Authorization for Medical and/or Surgical Treatment

I hereby authorize Dr._____ (and assistance the doctor may designate) to administer as is considered therapeutically and/or diagnostically necessary on the basis of his/her evaluation. I also consent to the administration of anesthetics as deemed necessary and surgical procedures of an emergency nature or non-emergency nature.

I understand that my pet's medical records may need to be shared with a consulting physician and I authorize this activity.

If I fail to claim my pet, written notice will be mailed to my current address listed on my pet(s)' record to remove said animal(s). Five days after such written notice, said animal(s) will be considered abandoned and may be disposed of in accordance with hospital policy. If the animal(s) are abandoned, it is understood that I am not relieved from paying costs for services at East Orlando Animal Hospital and the use of the hospital, including the costs of keeping said animal(s).

I also certify that no guarantee or assurance has been made as to the results that may be obtained. I assume financial responsibility for all charges incurred to patient, consent to release medical information, and authorize direct payment to East Orlando Animal Hospital.

I understand that a deposit is required upon admission of my pet into the hospital. I am leaving a deposit of $_____ today and will pay the balance of my bill at the end of treatment by:

☐ **MC** ☐ **VISA** ☐ **DISCOVER** ☐ **CHECK** ☐ **CASH**

I hereby certify that I have read and fully understand the above authorization for medical and/or surgical treatment.

_____

Name of Owner (Printed) **Date**

_____

Signature of Owner or Responsible Agent

_____

Telephone number where I can be reached

_____

Patient Name