Animal Emergency
Hospital of Redmond

# Alternate Authorization

Client Name:_____ Date:_____

Pet Name(s):_____

Authorized Person:_____ Phone Number:_____

Authorized Person:_____ Phone Number:_____

Effective Dates:_____

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I authorize the above named person(s) to approve diagnostic services, treatment and procedures for my pet(s) as recommended by a Veterinary Physician.

_____ This authorization is effective for the above dates only.

_____ This authorization should be made permanently for my account.

I understand that I will be held responsible for all charges from any diagnostics and/or treatment. As a precaution, I may leave my credit card information with the Hospital Manager.

Signature:_____

Additional Comments: