Sequoia Veterinary Hospital, Inc
255 Old County Road, San Carlos, CA 94070
650.369.7326 / 650.369.4403 (fax)

TREATMENT AUTHORIZATION FORM

Owner's Name: ______________________________ **Pet's Name(s):** ______________________

By signing below I authorize the following people to act on my behalf as agent for my pet in the capacities I've indicated for the time-frame noted.

Signed: ____ **Date:** ________________________

Name: ____________________________ Relationship to owner: ____________________

Phone Number: ______________________

Check boxes: Indicate time-frame: ______________ **-or-** ☐ Until further notice

☐ Make and attend appointments. ☐ Make general medical decisions. ☐ Make critical medical decisions.

☐ Provide payment for services or I authorize use of my credit card.
Time-frame: ______________ **-or-** ☐ Until further notice

Name: ____________________________ Relationship to owner: ____________________

Phone Number: ______________________

Check boxes: Indicate time-frame: ______________ **-or-** ☐ Until further notice

☐ Make and attend appointments. ☐ Make general medical decisions. ☐ Make critical medical decisions.

☐ Provide payment for services or I authorize use of my credit card.
Time-frame: ______________ **-or-** ☐ Until further notice

Name: ____________________________ Relationship to owner: ____________________

Phone Number: ______________________

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Name: ____________________________ Relationship to owner: ____________________

Phone Number: ______________________

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