

ANIMAL CLINIC OF EAST AVENUE
18 EAST AVE
BROCKPORT NY 14420
(585) 637-8700

AUTHORIZATION FOR TREATMENT

I, _____, would like to have the medical care and treatment decisions
of my pet(s): _____

to be made by the Doctor(s) of the Animal Clinic of East Avenue, with representation on my behalf
from: _____ during my absence.

All attempts to contact me at the following address: _____

Phone number: _____ will be made, but in my absence I request the below
decisions to the care of my pet be made.

I authorize the person named above to make decisions based on the following:

*Minor/major medical or surgical care necessary to ensure comfort and quality of life for my pet(s).

ACCEPT _____ DECLINE _____

*Euthanasia due to desire to eliminate pain and suffering.

ACCEPT _____ DECLINE _____

* _____ **No** life resuscitation procedures should be employed if a life threatening disease/injury
was to overcome my pet.

* _____ **All** life resuscitation procedures should be employed if a life threatening disease/injury
was to overcome my pet.

*Any other necessary decisions to ensure the comfort and quality of my pet(s).

I will authorize medical care and treatment and take full responsibility for any financial debts

incurred for the above pet(s) as follows: _____ Without limitation
_____ amount up to \$ _____

***This authorization for treatment will remain in effect until requested otherwise.**

Signature: _____

Date: _____