Patient Authorization for Records Transfer

I, _____, hereby authorize
Patient or Guardian Name

_____ to release records of
Clinic or Doctor Name

_____ to
Patient Name (if different from above)

Silver Creek Dental & Vision Care
10315 19tth Ave SE, Ste. 102
Everett, WA. 98208
Phone 425 . 385 . 3170
Text 425 . 441 . 6644
contact @ SilverCreekDentalVisionCare.com
(Prefer emailed digital records: PDF files, JPEG radiographs)

Patient or Guardian signature _____

Date _____