# Patient Authorization for Records Release

I, _____, hereby authorize **Silver Creek**
Patient or Guardian Name

**Dental & Vision Care** to release records of _____ to:
Patient Name (If different from above)

_____
Clinic or Doctor Name

_____
Street Address

_____ _____ _____ _____
City State Zip Telephone Number

_____
E-mail Address

Patient or Guardian signature _____

Date _____