



Aspen Springs Dental
 7940 South University Blvd, Suite 200
 Centennial, CO 80122
 T. (720) 482-0793
 F. (720) 482-0796

AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.

Patient Name: _____

Release To: _____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following conditions(s):

___ Drug Abuse, if any

___ Alcoholism or alcohol abuse, if any

___ Sickle Cell Anemia, if any

___ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

___ Copy of complete dental chart

___ All treatment rendered in this office or by this doctor

___ Copy of dental x-rays

___ *Limited to treatment dates & for conditions described below:

___ Other (e.g. models – describe)

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Transfer of Records

___ Second Opinion

___ Other _____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on ____ (date supplied by patient); or ____ revoked in writing by patient; or ____ 180 days from the date hereof; or ____ under the following conditions:*

 PATIENT'S NAME (PLEASE PRINT)

 DATE

 PATIENT'S SIGNATURE

 DATE

 AUTHORIZED PERSON SIGNATURE

 DATE