Patient Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient _____

Relationship to the Patient _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released. I may revoke this authorization by notifying Aspen Dental in writing.

Signature of Patient (or Patient Representative) _____ Date _____

Printed Name of Patient (or Patient Representative) _____