Family & Cosmetic DENTISTRY
JoseLopez, DDS

Information Release/Request Form

Dr. Jose Lopez is requesting you to provide consent to release/request confidential patient information for patient .

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to request that Dr. Lopez restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. However, Dr. Lopez is not required to agree to such a restriction. If Dr. Lopez agrees to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that Dr. Lopez has taken action in reliance on your consent.

I, _____, hereby certify that I have read the provision set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between Dr. Lopez and myself.

Please release/request my dental records to:

Dr. Name_____	Dr. Jose Lopez
Email _____	info@jlcosmeticdentistry.com
Address_____	3400 Penrose Pl. #202
_____	Boulder, CO 80301
Phone _____	P: 303-442-5748
Fax _____	F: 303-442-5749
Date _____	