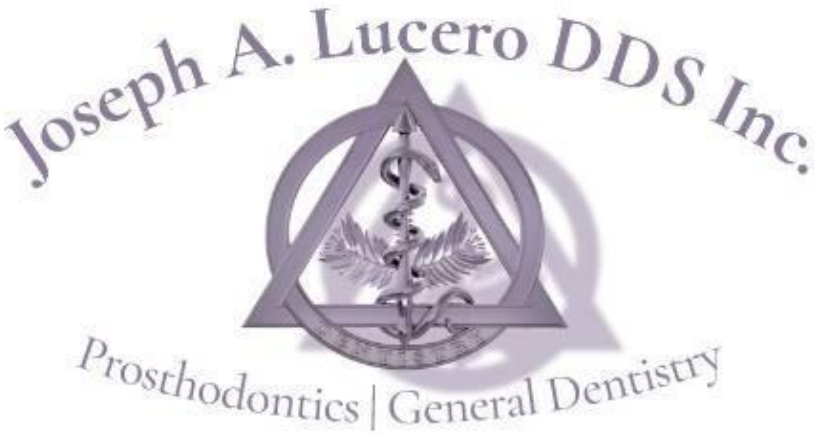

Authorization for Release of Dental Records and X-rays

I, (patient or guardian name) _____hereby authorize (doctor/dentist) _____ to release medical/dental records, x-rays, and any additional information to:

Joseph A. Lucero DDS Inc.
2575 Park Lane, Suite 101
Lafayette, CO 80026
Phone:(303)834-0615
office.luceroimplants@gmail.com

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Records being requested:

( ) Current X-Rays	( ) Dental Health Status	( ) Reports
( ) Diagnostic Casts	( ) Treatment Records	( ) Charts
( ) Health History	( ) Prescription Records	( ) Photos

( ) Others: _____

Signature of Patient/Guardian: _____ Date: _____