



Record Release Form

I, _____ hereby authorize
(Patient's Name)

(Former Dentist's Name)

to provide:

All in One Benso Family Dental

with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays, and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian, or POA of the patient, if patient is unable to sign for themselves)

Records should be sent:

All in One Benso Family Dental
2501 W. Happy Valley Rd
Suite 52-1310
Phoenix, AZ 85085
Fax: (623) 780-7515
Email: Bensodental@gmail.com

Date: _____