

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I authorize the office of \_\_\_\_\_  
to release my dental records, specifically, any dental x-rays taken within  
the last five years, any digital photos taken for the purposes of diagnostics,  
and my most recent periodontal charting to:

(please circle the designated office that you will be attending)

Eric Benson, DDS  
1648 Union Street, #202  
San Francisco, CA 94123

OR

Eric Benson, DDS  
774 Elmgrove Road  
Rochester, NY 14624

If you wish to email any of my information you may send it to:

info@ericbensondds.com

Thank you for your assistance and please do not hesitate to  
call me with any questions.

Patient Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_