DRS ENSOR JOHNSON & LEWIS

# Authorization for Release of Dental X-Rays and Patient Information

I, _____authorize the office of Drs Ensor Johnson & Lewis to release and forward my x-rays and/or patient information to:

_____

_____

_____

My reason for the request is:

_____Seeking a second opinion

_____Moving to another area

_____Other (please specify below)

_____

Signature of Patient (Parent/Guardian if Patient is under 18):_____

Date of Request:_____

Signature of Dental Staff Member:_____

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