DRS ENSOR JOHNSON & LEWIS

Request for Release of Dental Records

To:_____

From:_____

I request and authorize you to release my dental records to:

Drs Ensor Johnson & Lewis
11810 Parklawn Drive, Suite 101
Rockville, MD 20852
Phone- 301-881-6170
Fax- 301-231-9659
records@ejldental.com

Name of Patient:_____

Signature:_____

Relationship (if not the patient):_____

Date of Request:_____