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 x-rays and/or patient information to:

Please check box(s)

- ☐ Dental
- ☐ Orthodontic

Receiving Address/Email	Patient Name(s)
_____	_____
_____	_____
_____	_____

I also understand that if an original copy of a film is requested, that the office of Drs Ensor Johnson & Lewis is no longer responsible for that film and I will therefore not be able to request these films from the office again. Please allow 10 business days for processing.

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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