



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
North Bethesda, MD 20852
Phone- 301-881-6170
Fax- 301-231-9659
azhar@ejldental.com

Name of Patient: _____

Signature: _____

Relationship (if not the patient): _____

Date of Request: _____