Daniel Walenjus D.D.S. | Allison Scott-Walenjus, D.D.S., M.S.
147 Union Avenue, Manasquan, NJ 08736

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize Dr. Daniel Walenjus/Dr. Allison Scott-Walenjus to disclose certain protected health information about me to:

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(Name) (Address)

Dr. Daniel Walenjus/Dr. Allison Scott-Walenjus is hereby authorized to disclose the following protected health information
(Specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc):

All Medical/Dental Records X-rays Specific Information Listed Below:

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I understand that this request does not apply to: (1) certain health information that is not held in Dr. Daniel Walenjus or Dr. Allison Scott-Walenjus's medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose: Dental Treatment
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I understand that Dr. Daniel Walenjus/Dr. Allison Scott-Walenjus may not condition my treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to Dr. Daniel Walenjus/Dr. Allison Scott-Walenjus at the address listed above, and if I revoke this authorization, it will have no effect on actions already taken by Dr. Daniel Walenjus/Dr. Allison Scott-Walenjus in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient's personal representative.

Signature of Patient or Legal Guardian:_________________________ Date:_____________
Patient Name:____
Address:___________________________ City:______________ State:_______ Zip:_________
DOB:____________________ Phone:_______________________________
Printed Name of Patient or Legal Guardian:___________________________________
Witness:____