

**BLUE OCEAN DERMATOLOGY**  
**AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

In addition to the allowable disclosures described in the "Notice of Privacy Practices," I hereby specifically consent to the disclosure of my protected health information, including financial information, to the specified person(s) indicated below who are involved in my care:

1. Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

3. Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

4. Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

5. Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date