Flagler 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