
1515 S. Osprey Avenue Suite C-11 ● Sarasota, Florida 34239
Tel. (941) 955-0000 ● Fax (941) 955-1686

CONSENT TO PRIVACY PRACTICES

My signature below indicates that I have reviewed the web site posting of the ____1 page abridged notice of the privacy practices of Elliot M. Livstone, M.D., P.A. or the ____9 page complete notice of the privacy practices (check one or the other) of Elliot M. Livstone, M.D., P.A. I acknowledge that I have the opportunity to print a hard copy of this notice or not at my own discretion. I consent to the use of my personal health information by Dr. Livstone and the other employees of Elliot M. Livstone, M.D., P.A. for treatment, payment, or operations purposes. My consent is voluntary, but I understand that Dr. Livstone may refuse to treat me if I do not provide this consent. This consent is revocable, but if it is revoked, I understand that revoking this consent means that I have fired Elliot M. Livstone, M.D. and that he will not be responsible for providing me any further medical care, emergency or otherwise, from that moment onward.

Signed _____ Date _____

(If signed by a party other than the patient, please state the authorizing relationship)

REFUSAL TO CONSENT TO PRIVACY PRACTICES

My signature below indicates that I do not consent to the use of my personal health information for treatment, payment, or operations purposes in accordance with the terms and conditions of the privacy notice for this medical practice. I understand that Dr. Livstone will not see me or treat me in the absence of this consent. I understand that my refusal to provide this consent constitutes my firing Elliot M. Livstone, M.D., effective immediately, and that Dr. Livstone is not responsible for providing me any medical care, emergency or otherwise, from this moment onward.

Signed _____ Date _____

(If signed by a party other than the patient, please state the authorizing relationship)