

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

Surrogate - Telephone Authorization for Release of Health Information

Must be completed for ALL authorizations

In the event I am incapacitated or unable to speak to Dr. Livstone or to his office staff, I hereby authorize the full disclosure of my diagnosis and treatment with my health care surrogate who has been authorized to make health care decisions on my behalf. I understand that this authorization is voluntary, but in the absence of this authorization, the doctor and his office staff will provide no health information about me to my spouse, any other relative, or any other concerned individual. I understand that if the individual authorized to receive the information is not a health plan or a health care provider, the released information may not ultimately be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: _____ **ID Number:** _____

| | |
|------------------------------|--|
| Health Care Surrogate | Date of Authorization - Signature |
| _____ | _____ |
| _____ | _____ |

Description of the information to be disclosed if other than complete:

Must be completed for ALL authorizations

In the event I am temporarily incapacitated or unable to speak to Dr. Livstone or to his office staff, I hereby authorize the full discussion of my diagnosis and treatment with the following concerned individuals other than my health care surrogate. I understand that this authorization is voluntary, but in the absence of this authorization, the doctor and his office staff will provide no health information about me to my spouse, any other relative, or any other concerned individual. I understand that if the individual authorized to receive the information is not a health plan or a health care provider, the released information may not ultimately be protected by federal privacy regulations.

| | |
|--------------------------------------|--|
| Name of Concerned Individuals | Date of Authorization - Signature |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Any attendant or caregiver hired by me or for my benefit and any person I permit to accompany me into an Examination, Consultation, Recovery, or Hospital Room. _____

Must be completed for ALL revocations

I hereby revoke the authorization or disclosure of my individually identifiable health information to the individuals described below. I understand that health care information about me may have been released to the receiving individual prior to the date of revocation and that the revocation does not give me any recourse about information previously released.

Individuals receiving the information

Date of Revocation - Signature

Must be completed for ALL authorizations:

The patient or the patient’s representative must read and initial the following statements:

I understand that this set of authorizations will expire on December 31, 2020.

Initials: _____ Today’s date _____

I understand that I may revoke this authorization at any time by notifying the staff of Elliot M. Livstone, M.D., P.A. in writing. Should I do so, this action will not have any affect on any actions taken by the staff of Elliot M. Livstone, M.D., P.A. before they received the revocation.

Initials: _____ Today’s date _____

Telephone Answering Machine Authorization:

The patient or the patient’s representative must read and initial the following statement:

In the event that I am unable to come to the telephone, I hereby authorize the office staff of Elliot M. Livstone, M.D., P.A. to leave telephone messages for me on the telephone answering machine at the residence number I have provided.

Initials: _____ Today’s date _____

I understand that this permission will expire on December 31, 2020.

I understand that I may revoke this authorization at any time by notifying Elliot M. Livstone, M.D., P.A. in writing. Should I do so, this action will not have any affect on any actions taken by the staff of Elliot M. Livstone, M.D., P.A. before they received the revocation.

Initials: _____ Today’s date _____