UCI

I authorize University Center Imaging, to disclose the information I describe below:

by leaving it on the following message machine: **(please check one or more)**

□ My personal/home answering machine at (___) __________________________

□ Cell voice mail at (_____) _____________________

□ Work voice mail at (____) _____________________

□ Leave no messages

Description of information that may be disclosed: **(please check one or both)**

□ Appointment information

□ Billing information

In addition, you may disclose the above checked information , allow pick-up of your results and/or films to the following family members:

____

____

____

Expiration. This authorization will expire July 1, 2009.

Signature: ____ Date: __________

If this form is signed by someone who is not the patient listed above, provide the signor's name and his or her authority to act for the patient.

Signed by: _________________________

Authority to Sign on patient's behalf: ___________________________________

Revocation. You may revoke this form by sending a written letter to: Privacy Official, UCI 1800 W Hibiscus Blvd, Suite 100, Melbourne FL 32901. The letter must identify the name and date shown on the original form. It must include the date you wish to cancel. Your letter will not affect any actions taken before your letter is received.

If your information is given to others as allowed in this form, Federal privacy laws may not protect it.

University Center Imaging

an MTT Corporation facility

Patient Information Form -- **Please Print and *Complete All Entries***

PATIENT INFORMATION			**MR#_______________**
Mr. ( ) Mrs.( ) Ms.( ) Miss( )	**Marital Status M( ) S( ) D( ) W( )**		
PRINT (Last, First, Middle Initial)	**Date of birth**	**Sex**	**Social Security Number**
	/ /	M( )F( )	
PRINT (Mailing Address)	**Home #**		**Work #**
	( )		( )
PRINT (City, State, Zip)	**Email Address**		**Cell #**
			( )
Emergency Notification (Name)	**Relationship**		**Phone #**
			( )
Result of Injury? Yes( ) No( ) *Work( ) *Auto( ) Date of Injury _________________			
***Workers Comp or auto insurance information is required.**			

INSURANCE INFORMATION			
Primary Insurance Name		Secondary Insurance Name	
Name of Insured (Last, First, M.I.)	**Relationship**	**Name of Insured (Last, First, M.I.)**	**Relationship**
Social Security Number	**Date of Birth**	**Social Security Number**	**Date of Birth**
	/ /		/ /

AUTHORIZATION

I hereby authorize University Center Imaging to:

1. Provide treatment
2. Furnish my insurance company(s) with all medical information requested

The insurance information given by me is correct. I authorize and assign payment, under the terms of my policy, directly to University Center Imaging. I understand that I am financially responsible for charges not paid by my insurance including deductibles and copays.

______________________________ ______________________________

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of Medical Technology Transfer Corporation's Notice of Privacy Practices that is effective April 14, 2003.

______________________________ ______________________________

Signature of Patient/Guardian Date

If this form is signed by someone who is not the patient listed above (e.g., a parent/guardian/legal representative), please provide the signor's name and his or her authority to act for the patient.

Signed by:_____________________________

Authority to Sign on patient's behalf:___________________________________

If this acknowledgement is not signed, please provide a description of your efforts in obtaining the signed acknowledgement and the reason and acknowledgement was not obtained.____________________ ______________________________

____

Print Name:____Date:_________________