

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, 2008.

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.