PROFESSIONAL IMAGING CENTERS

		/ tocount #.			Date of Service		
Patient's Name:_	atient'sName:			Date of Birth:Social S		ity:	
Guarantor Name	e:		Email Addres	ss:			
Address:			City/S	State		Zip Code:_	
Phone:		Cell:		Woi	rk / Other:		
May we contact y	ou at any of the phone	numbers listed above t	to discuss medical and	I financial issues	s?Yes OR (Only at my	_ or
Referring Physic	ian:		Phone Number	·	Fa	ax	
Primary Insurance	ce:		Policy No	:			
Secondary Insur	ance Name and Polic	sy #:					
Auto Accident: A	Attorney Name & Phor	ne Number:					
Is the above info	ormation accurate and	I correct? Yes	No (write cor	rect address/p	hone number b	elow)	
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PROFESSIONAL IMAGING CENTERS, INC.
1049 WILLA SPRINGS DR., STE 1051, WINTER SPRINGS, FL 32708; Phone: (407) 657-7979 FAX (407) 678-9938

HIPPA AND DISCLOSURE AUTHORIZATION FOR INFORMATION REQUEST

Name:		Date of Birth:	
I acknowledge that a copy of the Notice of Priva disclosed, protected, and how I can get access	•	s how patient confidential information will be used, ailable to me upon request.	
•	ought) to disclose the fol	AA), I hereby authorize the following providers: (List lowing protected health information to Professional	
(Check as applicable) ☐ Copies of any diagnostic imaging tes ☐ Medical history, including specific pre procedure's progress or outcome. ☐ A list of allergies. ☐ Results of relevant diagnostic or laboration. ☐ Other:	ogress notes regarding a	seven years. ny problems that would impact surgery or	
		rpose of preparation for an outpatient procedure at his authorization shall be in force and effect until:	
I understand that, as set forth in the health care ing at any time by sending written notification to		I have the right to revoke this authorization, in writ-	
	al Imaging Centers - Attn: ng Dr., Suite 1051, Winte		
 healthcare providers that will be providing me I understand that a revocation is not effective of the protected health information. I understand that information used and disc recipient andmay no longer be protected by 	edical treatment or service to the extent that the he losed pursuant to this are federal or state law.	oorts regarding my radiographic exams to treating e to me. ealth care facility has relied on the use or disclosure athorization may be subject to re-disclosure by the at on whether I provide authorization for the request-	
RELEASE OF PROFESSIONAL IMAG	GING CENTERS' REC	ORDS (REQUIRES 48 HOURS NOTICE):	
	ds to any guarantor of pa	al Imaging Centers, Inc. to release medical, financial ayment on my account, any insurance company for low:	
Name:	_ Relationship:	Phone:	
Name:	_ Relationship:	Phone:	
Name:	_ Relationship:	Phone:	
Signature of Patient or Personal Representative		/	
Print Patient's Name or Personal Representative	Description of Personal Representative's Authority		
Fax Reports To: Professional Imaging Centers_			
,		ULTRASOUND-2 (06/17)	