

FAX TO: 856-589-0545

PRACTICE INFORMATION

PRACTICE NAME: _____

CONTACT PERSON: _____

ADDRESS: _____

CITY/TOWN: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____ FAX #: _____

E-MAIL (for practice): _____ E-MAIL (for online alerts): _____

I want to receive reports via (check all that apply):

- ____ Online Service
- ____ Fax (to Fax # _____)
- ____ Mail

HIPAA COMPLIANCE FORM FOR PHYSICIAN WEB ACCESS

I will be assigned a user name and password by Booth Radiology, which permits me to use the computerized medical image viewing service ("PACS network") of Booth Radiology for the purpose of viewing images and obtaining other clinical information regarding my patients. I agree that the issue of a user name and password and my use of such user name and password are subject to the following conditions:

1. **PASSWORD/USERNAME CONFIDENTIALITY:** I will not divulge my password, user name or any other information required to access the PACS network to any other person, nor shall I permit any other person to use my user name and password so that they are not unintentionally divulged.
2. **USE FOR TREATMENT ONLY.** I will use my user name and password only to gain access to images of patients who I am currently treating or evaluating for treatment. I understand that I have no right to view images or other information about persons who are not my patients, and I agree that I will not do so.
3. **COMPLIANCE WITH APPLICABLE LAW.** I understand the Booth Radiology PACS network contains confidential information that may be protected under the Health Insurance Portability and Accountability Act of 1996, other federal laws, state laws, and the ethics rules of the medical profession.
4. **DUTY TO REPORT.** I will contact Booth Radiology immediately upon any of the following events:
 - a. Learning that my patients' images have been improperly accessed by a third party.
 - b. Learning that my password or user name is or has been in the possession of any third party; or
 - c. Learning of any other misuse of Booth Radiology's PACS network.
5. **MONITORING.** I acknowledge that my use of the booth Radiology's PACS network will be monitored and that upon discovery of my improper use or disclosure of patient images, my access to the PACS network may be terminated.

By signing below, I indicate my agreement with the foregoing terms; I acknowledge that Booth Radiology reserves its rights to take legal action against me if I cause it to be involved in legal action or to suffer damages as a result of y violation of any term of this agreement.

Signature: _____ Date: _____

Print Name: _____