PACS ACCESS CONFIDENTIALITY FORM

PRACTICE INFORMATION

PRACTICE: _____

PROVIDER: _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____ E-MAIL: _____

PACS ACCESS HIPAA COMPLIANCE

I will be assigned a unique user name and password by Guilford Radiology for the right to view images and reports for patients for whom I provide medical or diagnostic services. I understand that I have no right to view images or other information about individuals who are not my patients, and I will not do so when I am accessing or using the Guilford Radiology PACS.

1. **COMPLIANCE WITH APPLICABLE LAW:** I understand the Guilford 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. I will access or use information on the Guilford Radiology PACS network in compliance with such laws and ethical rules.

2. **DUTY TO REPORT:** I will contact Guilford Radiology immediately upon any of the following events:

   a) Learning that my patients' images or information has 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 images or information in the Guilford Radiology PACS network.

3. **MONITORING:** I acknowledge and understand that my use of the Guilford Radiology PACS network may be monitored and that upon discovery of 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 Guilford Radiology reserves its rights to take legal action against me if I cause it to be involved in legal actions or to suffer damages as a result of any violation of any terms of this agreement.

Signature: _____ Date: _____

Print Name: _____