MADISON RADIOLOGY

PACS ACCESS CONFIDENTIALITY FORM

PRACTICE INFORMATION

PRACTICE: _____

PROVIDER: _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____ E-MAIL: _____

PACS ACCESS HIPAA COMPLIANCE

I will be assigned a unique username and password by Madison 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 Madison Radiology PACS.

1. COMPLIANCE WITH APPLICABLE LAW: I understand the Madison 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 Madison Radiology PACS network in compliance with such laws and ethical rules.
2. DUTY TO REPORT: I will contact Madison 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 username is or has been in the possession of any third party, or
   c) Learning of any other misuse of images or information in the Madison Radiology PACS network.
3. MONITORING: I acknowledge and understand that my use of the Madison 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 Madison Radiology reserves its rights to take legal action against me if I cause it to be involved in legal actions or to suffer damages because of any violation of any terms of this agreement.

Signature: _____ Date: _____

Print Name: _____