
PACS ACCESS REQUEST FORM

Access Acknowledgement/ Competency Statement

I acknowledge receipt of my Operator Identification Password for the Diagnostic Imaging Services (DIS) Picture Archiving Communication Systems (PACS) and acknowledge my personal and legal responsibility for maintaining the integrity of the system. By accepting a password for us in the system, I accept that my personal code, user ID and/or password is:

1. CONFIDENTIAL and known only to me personally, and is not to be told to or shared with other persons. If others in my office require access to the PACS, a separate security access form will be completed and DIS will issue those individuals a separate user ID and password.
2. TO BE USED ONLY to gain access to information that is essential to the performance of my professional responsibilities as they relate to patients under my care that have had imaging procedure at DIS.
3. AN ESSENTIAL COMPONENT in protecting the patients' right to confidentiality of his/her medical information.
4. THE EQUIVALENT OF my signature will be attached to all actions taken by me in the system. System access activating may be tracked and audited.

I also understand that:

1. I have a legal obligation to keep confidential all information concerning patients that I may have access to and will only discuss information with employees who have a need to know the information in order to perform their job.
2. I will not intentionally attempt to gain access to areas that are not needed for the performance of my job.
3. I am solely and fully accountable for any information entered in the system under my password. This means that I must both log on to a terminal or PC for a session to begin and log off at the end of that session. I will notify DIS immediately if I suspect that someone has gained unauthorized access to my password.
4. Violation of this policy is grounds for DIS to terminate my access to their PACS.
5. I agree to comply with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the federal privacy regulations and the federal security standards.

My signature below acknowledges that I have read and understand the conditions under which a personal code, user ID and/or password has been assigned to me.

PHYSICIAN
NAME (PRINT) _____

DATE _____

SIGNATURE _____

NURSE
NAME (PRINT) _____

DATE _____

SIGNATURE _____