AMI Log #_____

AGREEMENT TO PARTICIPATE IN THE ATLANTIC MEDICAL IMAGING SYNAPSE FUJI PACS

Important
Read all sections carefully before signing. A copy of this agreement will be retained by Atlantic Medical Imaging (AMI.)

Purpose of Agreement:
In order to ensure compliance with ethical and legal standards concerning protected health information, all users of Integrad must sign this Agreement. To maintain security your password must be kept confidential.

Confidentiality Agreement:
I acknowledge and agree that since the SYNAPSE Fuji PACS is accessible by multiple facilities and separate institutions, my responsibilities and obligations toward maintaining the confidentiality and security of information applies to all data associated with any institution or facility using the SYNAPSE Fuji PACS and not just the organization(s) with which I am directly associated.

All information contained on the SYNAPSE Fuji PACS is private and confidential and is proprietary to AMI and/or the patient, as the case may be. Information is defined as all patient, employee, physician and/or other data concerning AMI and its related entities which appears in verbal, written or electronic form. I agree that, except as directed by an authorized officer of AMI or by legal process, I will not during such time as I am authorized to use the SYNAPSE Fuji PACS system to:

- Disclose any such information to unauthorized person;
- Permit any unauthorized person and/or personnel to examine or make copies of any reports or other information prepared by me, in my possession or control, or to which I have access, without just cause;
- Attempt to use any such information for my own advantage or personal purposes;
- Access information on patients for which I am not directly involved in their care;
- Divulge my passwords to anyone for any reason;
- Transmit unencrypted individually identifiable information through the Internet or any internal environment that is not secured from external users;
- Attempt to modify or circumvent system or application security mechanisms.

I agree that I will comply with all HIPAA privacy and security regulations, policies and procedures in effect at AMI, as amended from time to time.

I acknowledge that the unauthorized disclosure of information by me or by members of my staff may violate state or federal laws, accreditation standards and/or ethical standards and may cause injury to a patient, employee, physician or health care provider and/or to AMI. Unauthorized disclosure of information may result in disciplinary actions being taken against me.

Advice and Counsel:
I have had my questions, if any, about the information contained in this Agreement answered by a representative of AMI. I may call the AMI Privacy Compliance Officer any time with questions or concerns at 609-927-8265.

ATLANTIC MEDICAL IMAGING SYNAPSE FUJI PACS
USER REGISTRATION FORM
(PLEASE COMPLETE ONE FORM PER USER)

SECTION ONE: To Be Completed by the Privacy Officer of the Remote Office
Statement of Agreement:

The acting Privacy Officer for this office will act as security liaison with AMI. **To report any changes in your office personnel, please email: lcaruso@atlanticmedicalimaging.com.**

I have read the above and understand our responsibilities and hereby give authorization for AMI to enable electronic access to the SYNAPSE Fuji PACS clinical information system(s) for the office of:

_____ _____
Office Name Name of Privacy Officer for Office

_____ _____
Office Address & Phone Number Signature of Privacy Officer for Office

SECTION TWO: Remote Clinical Information Access – To Be Completed By Requester
By signing this Agreement, I agree to abide by the terms contained herein accepting full responsibility for my actions and hereby request access to the SYNAPSE Fuji PACS including protected health information. All required information must be completed prior to processing SYNAPSE Fuji PACS.

_____ _____
Requester Signature Requester Name (printed)

_____ _____
Requestors City of Birth Office Phone Number

_____
Email address

_____
Date

AMI Provider Relations Representative:_____

SECTION THREE*:* Validation – To Be Completed by AMI

Access Request is validated by AMI (signatory):_____

Print Name/Phone Number:_____

PLEASE FAX COMPLETED FORMS TO LIZ CARUSO AT (609) 653-8764.