

PACS Digital Imaging Sign-up Form

Physician or Requestor Name (please print clearly): _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Please note, to effectively view images your computer system must be at least a Pentium III (500 MHZ) PC running Windows 2000 or above, have MS Internet explorer version 6.0 and Adobe Acrobat Reader version 6.0 installed, and have a high-speed connection to the internet.

Privacy Notice:

The protected health information that you retrieve, print, or display on your computer is subject to the published HIPAA directives regarding patient privacy. Access to this information should be restricted in accordance with these directives. We recommend that you exit out of a patient's protected information immediately after review. You are responsible for ensuring that your username and password is not shared with any parties.

Limited support for this product can be obtained by calling the Vancouver Radiologists IT department at (360)449-4978 or by referring to the help document that will be sent along with your username and password.

Signature of requestor: _____ Date: _____

If requestor is non-physician:

I agree that this employee should have access rights to confidential and protected health information from Vancouver Radiologists information resources. I understand it is my responsibility to supervise the above named individual during the course of their duties and have signed my acknowledgment accepting full responsibility for their actions.

Manager's Signature: _____ Date: _____

Please return this form by fax to (360)449-4961