Vancouver Radiologists, P.C.
Web portal access form

Please return completed form by:
Fax: (360) 449-4961 or **Email:** marketing@vanrad.com

User Name *(please print legibly)*: ____

Specialty (please circle one): MD/DO / DC / PA-C / ARNP / RN / MA / Manager / Office Staff

Practice Name: ____

Address: ____ Ste: _____________________

City: ___________________________________ State: _____________ Zip: ________________

Phone Number: ____________________________ Fax Number: ____________________________

Email Address: ____

Type of Access Requested (please check one):

☐ **Single Access** (You can view reports/images of patients who were referred by providers only within your organization).

☐ **All Access** (You can view reports/images of patients who were referred by a provider outside of your organization).

Please provide a username and password (no more than 15 characters each). These are both case sensitive.

User Name: __________________________________ Password: ______________________________

System Requirements:

- Windows XP or above operating system (Not compatible with Macintosh)
- Internet Explorer version 8.0 or higher (Not compatible with Google Chrome, Mozilla, etc.)
- Adobe Acrobat Reader version 10 or above
- High-speed internet connection

Limited support for this product is available by contacting Vancouver Radiologists marketing department at: (360)449-4984 or marketing@vanrad.com.

Privacy Notice: The protected health information that you retrieve, print, or display on your computer is subject to HIPAA directives regarding patient privacy. Access to this information should be restricted in accordance with these directives. It is recommended 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.

Signature of requestor: ____ Date: ___________________

A manager's signature is preferred if requestor is not a referring provider.

I authorize the employee listed above to have access to confidential and protected health information from Vancouver Radiologists' information resources. I understand it is my responsibility to supervise this individual during the course of their duties and accept full responsibility for their actions.

Manager's signature: ____ Date: ___________________

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