



Vancouver Radiologists, P.C.
Web portal access form
 Please return completed form by:
Fax: (360) 882-1007 or **Email:** IT@vanrad.com

First & Last 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: _____

Users must agree and adhere to the following as conditions of access:

- I will only access information relating to patients under the care and treatment of my medical group.
- I understand that actions of this user account are monitored and logged according to Vancouver Radiologists' policy.
- All information stored on, or obtained from, this website system remains the property of Vancouver Radiologists and is confidential.
- I understand that I am not allowed to download any sensitive files or PHI data to a personal device. I will delete any sensitive files or PHI data inadvertently downloaded and stored on a personal device. I will not transfer data to any storage cloud services such as Dropbox or Google Drive.
- I will not divulge my password to others nor will I allow others to log into this system under my login. I will not utilize user ID and password auto save functionality on any computer or mobile device. I will not log into this system under another person's login.
- I agree to immediately notify Vancouver Radiologists of any instances where I know, or suspect, unauthorized access to the web server using my login and password.
- I understand that in the event that Vancouver Radiologists suspects a possible breach of security associated with my account, they may, without prior notification, suspend privileges associated with my account.
- I understand I am accountable for all actions and events resulting from the use of this account.

Please provide a username (no more than 15 characters). Once we receive your request for access, you will be provided a temporary password, and will be prompted to select a password at your first login.

User Name: _____

System Requirements:

- Windows XP or above operating system
- Adobe Acrobat Reader version 10 or above
- High-speed internet connection

Limited support for this product is available by contacting Vancouver Radiologists IT department at: (360) 254-4914 option 3 or IT@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: _____