



**RADIOLOGY LTD., PLC and RLC, LLC
ACCESS AUTHORIZATION FOR ORDERING PHYSICIANS AND STAFF**

Radiology Ltd., PLC and RLC, LLC (collectively hereafter referred to as "Radiology Ltd.") grants the following physician or group practice and their respective authorized owners, employees, agents, and independent contractors ("Authorized Persons") access to Radiology Ltd. patient reports/images or both with the express understanding that the access is necessary to perform treatment, payment, and/or healthcare operations activities and that such physician or group practice and its Authorized Persons will safeguard the security and confidentiality of the Protected Health Information (PHI) contained in the patient reports/images in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other relevant State and Federal laws. It is further understood that it is the physician's or group practice's responsibility to ensure that all of their Authorized Persons abide by Radiology Ltd.'s PHI confidentiality and security requirements, including but not limited to the following: (a) passwords are not to be shared, (b) all patient searches must utilize at least one (1) other patient identifier in addition to the patient's first and last name, and (c) user names and passwords are not to be stored on any computer or remote access device that would permit automatic login if the machine is lost or stolen. User activity is monitored on a regular basis. User log-ins that are inactive for four (4) months in the case of a provider or two (2) months in the case of their staff will be deactivated. Radiology Ltd. will attempt to contact the user prior to deactivation.

The undersigned physician or group practice and its Authorized Persons expressly agree to limit his/her or its access to and use of Radiology Ltd.'s patient reports/images database to only the reports and images of his/her or its patients and only for proper treatment, payment, or health care operations (such as quality assurance, peer review, and so forth) purposes. The undersigned further acknowledges that accessing PHI without authorization, accessing or using PHI for an improper purpose, or allowing access to PHI by unauthorized persons constitutes a HIPAA Privacy Rule violation that could result in the loss of your privilege to access Radiology Ltd.'s database, possible criminal prosecution, and other sanctions and such unauthorized conduct may be reportable to law enforcement, professional licensure and disciplinary authorities and the Department of Health and Human Services. Physician and/or group practice on behalf of itself and its Authorized Persons further agrees to take all reasonable measures and precautions to ensure that the access to Radiology Ltd.'s database is only available during regular business hours. Physician and/or group practice shall immediately notify Radiology Ltd. when any previously Authorized Person is no longer associated with physician or group practice so that their access may be terminated. Radiology Ltd. reserves the right to audit all access to ensure compliance with these requirements.

Availability of online images cannot be guaranteed due to potential technical difficulties, which may be beyond the control of Radiology Ltd. It is essential that any images required for surgery or other invasive procedures be obtained in hard-copy form. It is the responsibility of the physician performing these procedures to obtain CD, paper or film copies of the necessary images in advance.

System Access requested for: RadVision/Amicas (TMC or St. Joseph's) RadVision RadVision Reach

Type of Affiliation with Radiology Ltd: Hospital Staff Referring Provider

Type of access action to be taken: ADD CHANGE DELETE

Practice Name: _____

Name of Authorized Employee: _____ Hospital ID (if applicable): _____

Signature of Authorized Employee: _____

Responsible Contact's Name (i.e. Physician, Administrator, or Office Manager): _____

Responsible Contact's Office Address: _____

Responsible Contact's Job title: _____

Responsible Contact's Telephone: _____

Responsible Contact's email: _____

Responsible Contact's Signature: _____ Date: _____

Please fax completed form to (520) 545-1726.

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