

# Application for Radiology Image Viewing Privileges at MCH

\* Required Field

Title: \_\_\_\_\_ \*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_

\*Business Address: \_\_\_\_\_  
\_\_\_\_\_

Business Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

\*Driver's License Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Place a check next to each system you need access.

<input type="checkbox"/>	DR Systems	Patient Information system, Orders, Reports, and Images
<input type="checkbox"/>	DR Web	Radiology Images and Reports
<input type="checkbox"/>	PICOM Online	Cardiology and Radiology Images and Reports
<input type="checkbox"/>	Night Hawk	After hours emergency reports

***Fax this completed form along with a copy of your driver's license to (432) 640-1393***

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## Confidentiality Statement

I understand that my password is unique and not transferable. I agree that I will not share my password with anyone.

I understand that I have a legal obligation to keep confidential all information that I have access to and will only discuss information with others who have a need to know the information in order to perform their work. Release of unauthorized information will result in disciplinary action taken by the hospital against me, up to and including revocation of computing privileges.

I will not intentionally attempt to gain access to information that is not needed for the performance of my work.

I understand that I am solely and fully accountable for any information entered in a computer system with my password.

I will notify the I.T. Security Officer immediately if I suspect that someone has gained unauthorized access to my password.

I understand that I must not remove any information from MCH premises without proper authorization.

I understand that MCH reserves the right to monitor, review, audit, intercept, access and disclose all matters on MCH computers at any time, with or without notice and that such access may occur during or after working hours. I am aware that use of a password on a computer system does not restrict the right to MCH to access my electronic actions.

My signature above acknowledges that I have read and understood the policies and procedures governing computer use on the eMed/IDX PACS/RIS system at MCH.

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## Radiology Approval:

\_\_\_\_\_  
Carol Evans, Radiology Director

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Date