CMI
CASCADE
MEDICAL IMAGING

(541) 389-XRAY Toll Free: (866) CMI-XRAY
(541) 389-9729 *(866) 264-9729*

Access and Confidentiality Agreement

(Physician/Employee/Volunteer/Student)

As a physician/employee/volunteer/student with access to medical images and reports from the Cascade Medical Imaging, LLC (CMI) PACS network you will have access to what this agreement refers to as "confidential information." The purpose of this agreement is to help you understand your duty regarding confidential information.

Confidential information includes patient information, medical images, and reports. You may learn of or have access to some or all of this confidential information through a computer system or through your employment activities.

Confidential information is valuable and sensitive and is protected by law and by strict policies of CMI. The intent of these laws and policies is to assure that confidential information will remain confidential - that is, that it will be used only as necessary to provide authorized patient care.

As a physician/employee/volunteer/student, you are required to conduct yourself in strict conformance to applicable laws and the policies of CMI governing confidential information. Your principal obligations in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties will subject you to discipline, which might include, but is not limited to, termination of employment and to legal liability.

Accordingly, as a condition of and in consideration of your access to confidential information, you promise that:

1. You will use confidential information only as needed to perform your legitimate duties as a physician/ employee/volunteer/student receiving information from CMI. This means, among other things, that:

   A. You will only access confidential information for which you have a need to know; and
   B. You will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized by CMI.
   C. You will not misuse confidential information or carelessly care for confidential information.

2. You will safeguard and will not disclose your access code or any other authorization you have that allows you to access confidential information.

3. You accept responsibility for all activities undertaken using your access code and other authorization.

4. You will report activities by any individual or entity that you suspect may compromise the confidentiality of confidential information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.

5. You understand that your obligations under this Agreement will continue after termination of your employment. You understand that your privileges hereunder are subject to periodic review, revision and if appropriate, renewal.

6. You understand that you have no right or ownership interest in any confidential information referred to in this Agreement. CMI may at any time revoke your access code, other authorization, or access to confidential information. At all times during your employment, you will safeguard and retain the confidentiality of all confidential information.

7. You will be responsible for your misuse or wrongful disclosure of confidential information and for your failure to safeguard your access code or other authorization access to confidential information. You understand that your failure to comply with this Agreement may also result in your loss of employment and other legal liability.

8. I attest that I have completed annual HIPAA training :_______________
Initial Here

____ **Name** (Please <u>print</u> your first and last name)

____ **Title** (e.g., M.D., R.T., R.N., Coder)

_________________ **NPI Number** (if applicable)

_________________ **Staff ID** (if applicable)

(______) _________________________________ **Work PHONE Number and Extension**

____ **Clinic/Hospital Name**

____ **Department**

____ **Street Address**

_________________________ **City** _____ **State** ___________ **Zip**

(______) _________________________________ **FAX Number** to receive patient reports

____ **Work EMAIL address**

____ **Primary Use of Application**

____ **Supervisor's Name**

(______) _________________________________ **Supervisor's Phone Number**

For all access <u>other than physicians</u>, please print your supervisor's name and phone number above for verification.

____ ***Signature*** of Physician/Employee/Volunteer/Student

________________________________ ***Date***

FOR INTERNAL USE ONLY

Supervisor Verification by:	_____ on	___________	State License Verification by:	_____ on	___________
NPI Verification by:	_____ on	___________	PECOS Verification by:	_____ on	___________
Access Granted by:	_____ on	___________	HR Notification by:	_____ on	___________

Please fax this form to CMI to receive your Login ID and Password.
Fax Number: (541) 318-8547