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

This agreement is entered into on ____________________, by and between Central Oregon Radiology Associates, P.C. (CORA) and on behalf of Cascade Medical Imaging, LLC (CMI) and Central Oregon Magnetic Resonance Imaging (COMRI) and ____ (User).

WHEREAS, CORA makes accessible to authorized Users its Information Systems (s), for the sole and specific purpose of providing healthcare and/or healthcare services. CORA's information systems contain a broad range of electronically stored medical information about patients, including Protected Health Information.

____________________________________ (User) requires access to the medical information stored in one or more of the following systems:

Sectra (PACS)	MagView	Citrix
Royal RIS	Royal MD	Nuance/Powerscribe

CORA grants access to the healthcare information systems listed above for the purpose of providing healthcare and/or healthcare services to patients. Access is granted based on the individuals organization and role.

User acknowledges the following:

1. ***Definitions:***
   a. Protected Health Information (PHI) is defined as 45 Code of Federal Regulations (CFR) 160.103 (HIPPA Regulations). PHI includes patient-identifiable clinical and demographic information in any form (electronic, written, or verbal).
   b. Healthcare and healthcare services include treatment, payment and operations (TPO) as defined in 45 CFR 164.501.
   c. User means the individual who is authorized to have access to CORA managed medical information systems.

2. ***Terms of Access:***
   a. Information accessed and/or retrieved from the system(s), is intended only for the review and/or use of the User based on the User's legitimate healthcare or healthcare service-related duties. Access or retrieval of information from the systems for any other purpose is expressly prohibited.

3. ***Agreements and Conditions of Access and Use:*** In consideration for use of the systems, the User agrees to the following terms and conditions:
   a. To access PHI only for the purpose of providing healthcare and/or healthcare services based organizational role and required job duties.
   b. To access the minimum amount of information needed to complete job duties.
   c. To safeguard and not share or give their authentication credentials (login ID and/or password) with any other individual; to take appropriate measures to safeguard their authentication credentials; to accept responsibility for all activities undertaken under said authentication credentials.
   d. To not use of disclose PHI other than as permitted or required by law or as authorized by the patient.
   e. To use appropriate safeguards and practices to prevent use of disclosure of PHI other than as provided in this Agreement, including but not limited to the following:
      i. User will not divulge, copy, download, sell, loan, alter or destroy any PHI except as explicitly authorized by CORA.

        ii. User will not leave PHI displayed on an unsecured computer screen and will log out of the system before leaving an unsecured area.
    f. To report activities by any individual or entity that User suspects may compromise the confidential of PHI to CORA's Privacy Officer. Reports made in good faith are held in confidence to the extent permitted by law, including the name of the individual reporting the activities.
    g. To promptly notify CORA when changes occur in their scope of practice or job duties which would eliminate or materially affect their need for access.

4. ***Completion of HIPPA Education:*** user agrees and warrants that they have received HIPAA education and understands their responsibilities as outlined in the Privacy and Security rules.

5. ***Termination***: CORA may at any time revoke User's authorization credentials for reasons including but not limited to:
    a. Inappropriate access
    b. System inactivity
    c. Activities that may compromise the protection or confidentiality of the PHI.

Please provide the following information:

Name:	**Company Email:**
Title:	**Company Phone:** **Department:**
Clinic/Hospital Name: **(if other, please specify):**	
Organization Role: **Referring Provider (NPI Required)** **Technologist** **Medical Staff**	 **Administrative Staff** **Other**
Company Address:	**Signature:**

By signing below you are, acknowledging that you are the supervisor of the requestor/user listed above and both you and the requestor are currently employed by the clinic/hospital listed above.

Supervisor's Name:	**Supervisor's Company Email:** **Supervisor's Phone:**
Supervisor's Signature:	**Date:**

*Fax completed form to the CMI IT Help Desk at **541-318-8547**.
For questions contact the Help Desk at **541-389-9729**, Toll Free at **866-264-9729**.