



PACS Confidentiality and Security Agreement

I understand the facility or business entity (the “Company”) in which or for whom I work or provide services, or with whom the entity (e.g. physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information with Larchmont Medical Imaging, through a picture archiving and communication system.

In order to facilitate the care of patients I will be authorized to have electronic access to Protected Health Information as such term is defined in the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereon (the “HIPAA Privacy Rule”) through the Larchmont Medical Imaging (LMI) PACS information system (the “System”). I agree to abide by all LMI policies and procedures relating to System security, patient confidentiality, and the use of the System.

In the course of my employment/assignment at the Company, I understand that I may come into the possession of Protected Health Information via PACS. I will access and use this information only, when it is necessary to perform my job related in accordance with the terms of this Agreement as otherwise provided by law. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Protected Health Information.

I have been assigned a password to access the System. My password is the legal equivalent of my signature. I will not divulge my password nor attempt to learn another person’s password. If the security of my password is compromised, I will notify LMI immediately (609-261-4500 x1240).

I will not authorize anyone to use my password for any reason. I am responsible for all usage on my password. My usage may be monitored at any time and by any means.

I will access the System only for appropriate purposes related to patient care. I will not engage in any inappropriate use of the System.

I will not access, copy or remove Protected Health Information from the System unless it is appropriate for patient care.

I will implement appropriate safeguards to prevent the unauthorized use of the System by my employees, agents and subcontractors. I understand that I am responsible for the misuse of the System or Protected Health Information by any such employee, agent or subcontractor.

All electronic data created, stored, or transferred through the System is the property of LMI. LMI reserves the right to monitor, access, review, and disclose information contained in the System without advance notice and/or without my consent.

The unauthorized viewing of Protected Health Information; copying of data/files; or wrongful dissemination of Protected Health Information is a direct violation of LIA policy and this agreement.

If I have reason to believe that there has been a misuse of the System or Protected Health Information, I will contact LMI immediately.

During and after the termination of this Agreement, I will keep confidential any Protected Health Information to which I have access through the System.

I agree to abide by the HIPAA Privacy Rule in all respects as it pertains to my use of the System.

I agree to indemnify and hold harmless LMI, its subsidiaries, affiliates, successors and assigns against and from any and all claims, demands, actions, suits, proceedings, costs, expenses, damages, and liabilities, including reasonable attorney’s fees, arising out of, connected with or resulting from unauthorized access to the System or misuse of Protected Health Information.

Violating any term or condition of this Agreement may subject me to certain actions by LMI including, but not limited to, the loss of System access privileges and notification of law enforcement officials and regulatory, accreditation and licensure organizations.

I have read and agree to abide by the terms contained in this Agreement.

Name (print):	Signature:	Date:
Professional Title: Circle One Physician Medical Office Staff	Access: Circle one Reports Only Images & Reports	Physician Practice/Hospital Name
Practice Address:	Phone Number:	Email Address: