Bayside Imaging | epic Care Partners in Comprehensive Care

NUVODIA

INFORMATION SYSTEMS SECURITY AGREEMENT

I (the undersigned) do hereby agree to comply with the following policies in the performance of my assigned duties in using Nuvodia, LLC information systems or in access to Nuvodia, LLC licensed software product(s).

I agree that I will:

(1) not use, share, disclose, release, divulge, or provide access to any individually identifiable health information (health information relating to the past, present, or future physical or mental health or condition of an individual or information that identifies or can potentially be used to identify an individual) except for treatment, payment and healthcare operations as identified by HIPAA regulation; or to the individual;

(2) not attempt to access any patient information to which I have not been granted access authorization, or for which I am not directly involved in the continuum of patient care, including but not limited to application modules, programs, patient records and personnel records;

(3) keep my assigned password(s) in strict confidence;

(4) not attempt to access the system using another user's password;

(5) request a new password if I feel my password has been compromised;

(6) report any known security violations to Nuvodia's Information Systems Department;

(7) not reveal any proprietary or confidential business or organizational information to any third-party without express written authorization from the applicable entity listed above; and

(8) Export only those studies for patients for whom I am a physician of record or in the continuum of care, through the DICOM export capabilities of the PACS software application.

I understand that breach of these policies constitutes grounds for disciplinary actions up to and including termination of my access to such computer systems.

Signature: _____ Date: _____

Printed Name (First, MI, Last): _____

Date of Birth: _____ Title/Position: _____

Email Address: _____

Affiliated Office, Facility, or Entity Name: _____

Request is for access to which entity's images: _____

REQUIRED FOR PROVIDERS ONLY

NPI#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Group name: _____ Specialty: _____

SUPERVISOR'S CONTACT INFORMATION AND SIGNATURE – REQUIRED FOR ACCOUNT ACTIVATION

Authorized by (signature): _____ Date: _____

Authorizer's printed name: _____

Email or direct phone number: _____

Please send completed form to alexandria.black@epic-care.com