Wake Radiology Services, LLC and Affiliated Companies ("Wake Radiology")
Referring Provider Computing Account Request and Security Agreement

I request that a Referring Provider Computing Account ("Account") on Wake Radiology's computer network and related hardware and software systems ("System") be established for my use, and, in consideration of the establishment of such account, I hereby agree to abide by the following guidelines established by Wake Radiology.

1) I represent and warrant that I will use this Account to review radiological reports and images for patients that are under my care or who have authorized me pursuant to a valid HIPAA Authorization to view such information.

2) I understand that medical images displayed by the System are for clinical review only and must not be used for primary interpretation.

3) I understand that I am prohibited by HIPAA regulations, and other applicable laws, from accessing Protected Health Information (PHI) for patients who are not under my care and for patients who have not authorized me to access such PHI. I will promptly contact Wake Radiology at the number indicated below upon any of the following events:
    a. I learn that a patient's images or reports have been improperly accessed by a third party;
    b. I learn that my password and user name is or has been in the possession of any third party;
    c. I change my employment status or practice; or
    d. I learn of any misuse of Wake Radiology's RIS-PACs web information.

4) I also understand that the System provides an electronic record or audit trail listing all personnel who have viewed or modified PHI for a specific patient and I authorize Wake Radiology to provide this trail to the patient on such patient's request.

5) **I agree to indemnify and hold Wake Radiology harmless from any and all claims, including damages, losses, liabilities, and costs (including attorneys fees and court costs), penalties and fines, which may result from improper disclosure or use of PHI using the password that has been assigned to me.**

6) I understand and agree that this Account is for my sole use and I will not permit any other person to use this Account for any purpose. I will not share the Account password with anyone else, and I will take appropriate security measures to ensure that the password is not accidentally revealed. I also agree that if I have reason to believe that the password has been compromised, I will change it immediately. I acknowledge and agree that I will be accountable for any and all improper use of this Account.

7) I will never use a Wake Radiology Referring Provider Computing Account other than this Account, or an account for which I am the registered user.

8) I agree that, should I leave my practice/hospital or change positions so that the Account is no longer needed or appropriate, I will promptly notify the Wake Radiology help desk (919) 788-7885 to terminate my access to the Account.

9) I understand that this Account is a license to use facilities owned and operated by Wake Radiology, and acknowledge and agree that use of this Account is subject to the rules, regulations, and policies of Wake Radiology and all applicable State and Federal laws, as they may change from time to time. In particular, Wake Radiology may modify the terms and conditions of this Agreement by providing written or electronic notice to me from time to time.

10) I will comply with applicable laws, regulations, and professional standards and guidelines at all times in connection with my use of this Account, including without limitation, all laws governing copyright, privacy, and the practice of medicine. I will not illegally use, inspect, copy, or store any copyrighted computer software programs or other material in connection with this Account. I agree not to attempt to defeat or circumvent security measures nor to reverse engineer any software program in connection with this Account. I will not cause damage to computer systems or computer networks or intentionally damage equipment, software, or data belonging to Wake Radiology or other users.

11) I will follow prescribed guidelines when using diskettes, compact discs and other electronic media to avoid, to the best of my ability, introducing viruses into computer systems used in connection with this Account.

12) I understand that failure to abide by the terms of this Agreement may result in cancellation of my Account and may subject me to civil or criminal liability.

13) I acknowledge that Wake Radiology makes no guarantees or warranties that the System or this Account will operate in an uninterrupted fashion or without errors. All use of the System and this Account is at my own risk. Access to the System is provided on an "AS-IS, AS-AVAILABLE" basis.

14) I understand and agree that Wake Radiology may suspend or terminate this Account at any time upon notice to me.

Name (print):_____Position/Title:_____

Signature:_____ Date:_____ NPI#:_____

Practice/Hospital Name:_____

Address:_____
Street (no PO boxes please) City ST Zip

Phone:_____ Fax:_____ Email:_____

Which of your devices requires Wake Radiology RIS-PACS installation? Please indicate the operating system for each (Windows, Mac, Android, IOS (iPad)).

None _____ Desktop _____ Laptop _____ Tablet _____

IT Support Contact Name:_____ Title:_____

Phone:_____ Email:_____

Do you practice at another location? Yes _____ No _____

If yes, do you want the Wake Radiology RIS-PACs installed at this second location? Yes _____ No _____

For non-physicians who are requesting an Account, please also have an authorizing physician complete the information below:

I request that an account be established for the person listed above and confirm that they are authorized to view Protected Health Information for patients under my care or the care of other physician-members of my practice. **I agree to be responsible for any indemnity, fine, or penalty that may be incurred by Wake Radiology by reason of the misuse of the account assigned at my request or unlawful disclosure of PHI using such account.**

Authorizing Physician Name (print):_____ Title:_____

Authorizing Physician Signature:_____ Date: _____

Please complete all the information above, including contact information, appropriate signatures and dates.
Fax both pages of this agreement to Wake Radiology at (919) 781-9792.
We will notify you by phone or email once your account has been established.