



## **IPRO Access**

**Physician requesting access:**

**Dr.** \_\_\_\_\_

**User Name:** \_\_\_\_\_

**Password:** \_\_\_\_\_

### **IPRO Access**

- <http://mristudies.com/ipacs/>
- *Download viewer (red icon, top left screen)*

### **Need Assistance**

*Contact Michael Bennett @ 478-719-9942*

### **HIPAA Confidentiality Agreement**

- **SIGNED:**    *YES*    *NO*

### **Experience the Advantage of iPRO Access!**

- ✓ *Image access in seconds – even over dial-up connection*
- ✓ *View images from any PC with a standard Web-browser*

*[www.suncoastopenmri.com](http://www.suncoastopenmri.com)*

*Accredited by the American College of Radiology*

**(850) 747-8822 / FAX (850) 747-8664**

**511 E. 23<sup>rd</sup> Street, Panama City, FL 32405**

I, \_\_\_\_\_, understand the policies of **Suncoast Diagnostic Imaging** regarding the confidentiality of patients' health care information whether in written, unwritten, or electronic form. I understand that this information belongs to the patient and I am only the caretaker and must guard the information appropriately. This includes, but not limited to, keeping health care information secure, private, and out of public view; not discussing patient-specific issues and information in public areas, and protecting computer data by logging off work stations when they are not in use. I acknowledge that I have been trained regarding our legal obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a health care provider. I pledge to abide by HIPAA's privacy rules and by any state laws that provide greater protection or rights to patients.

I hereby agree that I will access only the information that is necessary for me to perform my responsibilities. The patient records available through the SIM data source are only for the use of authorized physicians, nurses, employees, students, or staff who have signed confidentiality agreements on file with the entity from which these records are obtained. The records contain information which is privileged, confidential and exempt from disclosure under applicable law. Browsing for information regarding patients that are not under my immediate care is strictly prohibited, as is tampering or otherwise interfering with the electronic information delivery system. I have been advised that all activity will be tracked.

I understand that my obligation, as outlined above, will continue after my employment or association with the practice/facility end and that should I violate patient confidentiality appropriate sanctions will be taken.

My signature below attests to the fact that I have read, understand and agree to abide by the terms of this agreement.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_