DIAGNOSTIC IMAGING
CENTERS, P.A.

# Request For
# Online Image Portal Access

**Diagnostic Imaging Centers, P.A. (D.I.C.) Image Viewer is intended to be utilized by medical practices and their providers ("Practice") as a tool to support patient treatment. Access is granted on an individual basis upon request of the Practice, and by approval from D.I.C.'s HIPAA Security Officer, Dr. Jeffrey Herman, MD. Each approved User is issued a unique User ID and password; both of which will be emailed directly via the email address provided on the form.**

In our constant effort to maintain a network that is both safe and secure, in addition to meeting regulatory requirements, all Users must agree to the following terms of acceptance prior to obtaining access to D.I.C.'s Image Viewer.

## TERMS OF AGREEMENT:

1. All Users must stay in compliance with all of D.I.C.'s policies, as well as State and Federal regulations; including but not limited to HIPAA regulations.
2. All Users must comply with any additional security policies or changes to D.I.C.'s Security Policy that may be required in the future.
   ***NOTE: Any deviation by User from D.I.C.'s Image Viewer security policies will result in the revocation of network access for that User and potentially for that Practice.***
3. All Users must accept responsibility for educating themselves about D.I.C.'s Image Viewer Security Policies, and are expected to contact the HIPAA Security Officer with any questions regarding compliance or Security Policies. For technical assistance, Users may call 913-319-8400 ext. 1131.
4. All User IDs and passwords:
   - MUST be kept confidential.
   - MUST *only* be used by the approved/intended User, and cannot be shared.
   - MUST *not* be visible on any unattended data entry screen or imbedded in any automated program, utility, or application such as autoexec.bat.files, batch job files, terminal hot keys or otherwise saved on a PC or written/posted on or near a PC, monitor, keyboard, on or under the keyboard, mouse pad, or in any non-password protected PDA, etc.
   - MUST be alphanumeric and at least eight (8) characters long.
     - *Diagnostic Imaging Centers, P.A. uses a HIPAA-compliant password generator for passwords.*
5. All Users must respond promptly to D.I.C.'s annual network audits and verifications of compliance.
6. All PCs used to access D.I.C.'s Image Viewer will be licensed and Practice will be in compliance with the terms and conditions of those licenses. All PCs will have up-to-date anti-virus and firewall protection, Operating Systems, and applications.
7. Practice is legally responsible for all use and/or misuse of D.I.C.'s Image Viewer, and any information contained therein, by its members/shareholders and employees.
   *NOTE: Diagnostic Imaging Centers, P. A.'s Image Viewer should be solely accessed for facilitating the health care needs of Practices' patients.*
8. Practice will promptly notify D.I.C.'s HIPAA Security officer at 913-319-8400 of any applicable changes regarding the User's status within the Practice. If the User leaves the Practice, Practice will inform D.I.C. in order to ensure compliance with all related regulatory requirements and protect both parties from potential liability risks.
9. By signing this request form, User and Practice agree to be bound and to abide by all terms set forth on this request.

To gain access to D.I.C.'s Image Viewer, please complete the information below and return via one of the following options:

- Fax to: 913-955-3742
- Scan and email to: helpdesk@dic-kc.com
- Mail to: 6650 W. 110th St., Suite 200
  Overland Park, KS 66211

*NOTE: If you have not received your credentials within 3 business days of form submission, please contact our Help Desk at 913-319-8498.*

DIAGNOSTIC IMAGING CENTERS, P.A.

## Diagnostic Imaging Centers, P.A.'s Image Viewer Access Request Form

❑ *I acknowledge and agree to the Terms of Agreement set forth on this request.*

Full Name (Please Print): _____

Title: ❑ MD ❑ DO ❑ DC ❑ PA ❑ NP ❑ RN ❑ Other _____

Email Address: _____ Practice Phone #: _____

User ID and Password will be sent to this email

Name of Practice: _____

Signature: _____ Date: _____

➢ **If not a Provider, please complete the requested information below.**

Approving Provider: _____

Title: ❑ MD ❑ DO ❑ DC ❑ PA ❑ NP

Approving Provider's Signature: _____ Date: _____

**SUBMIT FORM**

**INTERNAL USE ONLY:** Date Received: _____Date Processed: _____