Web Portal Access Request Form

DATE:			
PRACTICE / GROUP NAME:			
PHYSICIAN (S) NAME:			
Address (City, Zip):			
Practice Phone Number:			
PHYSICIAN (S) PROVIDER CODE (NPI):			
Does physician have multiple locations? ☐ Yes ☐ No *(If, yes please list locations below)*			
Application:	☐ Royal MD Portal	☐ iConnect Web Portal	☐ Both

Radiology Associates, LLP HIPAA Agreement

Introduction

Radiology Associates, LLP is pleased to offer you access to our Physician Web Portal. As a valued referring clinician, this gives you immediate access to your patients' diagnostic imaging procedures and reports. By simply obtaining a unique user name and password, we are confident that you will find access to your patients' records is extremely easy and straightforward.

These portals contain patient's protected health information; therefore, federal and state laws require that Radiology Associates, LLP and the treating clinician take appropriate steps to protect against the unauthorized use and disclosure of such information. The Health Insurance Portability and Accountability Act ("HIPAA") allows health information concerning individual patients to be disclosed to another health care provider for purposes relating to the medical treatment of the patient. As you are well aware, we as Providers are required by HIPAA to safeguard this information.

To assure this protection of patients' protected health information from unauthorized use or disclosure, we ask that you agree to the following conditions:

Agreement

Regarding your use of and participation in the RALLP Physician Web Portal, you hereby agree to use protected health information accessed from using this web portal for the purpose of diagnosis and / or treatment of your patient(s), and for no other purpose except those permitted or required by applicable federal and state law. In addition, you agree to the following:

- Use appropriate safeguards to prevent the use or disclosure of patient information other than as permitted pursuant to this agreement or applicable federal and state law;
- Make certain that your employees or other agents who you authorize to access these portals comply with the provisions of this agreement and applicable federal and state law;
- Insure that each individual obtain and utilize a unique user name and password and to protect this information to prevent the unauthorized use or disclosure of those patient data;
- Notify the Radiology Associates IT Department when any authorized user of your organization is no longer in your employ / practice.
- Report to the Radiology Associates, LLP HIPAA Privacy Officer (Mrs. Donna Mosser) any use or disclosure of protected health information not permitted by this agreement or applicable federal and state law.

Radiology Associates, LLP reserves the right to terminate this agreement and your access to our web portals upon making a determination there has been a violation or breach of any of the terms and conditions of this agreement.

Authorized Users for my practice (include First Name and Last Name)

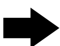
Name	Email Address	Request Type	If you are a staff member, can you order on behalf for "Entire Practice" or "Single Physician"- *Please list physicians name below if "Individual Physician is marked"*
Ex: Lori Test	testabc@gmail.com	☐ Physician ☑ Staff Member	☐ Entire Practice ☑ Individual Physician (s) **Test Smith MD, Test Anderson MD**
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)
		☐ Physician ☐ Staff Member	☐ Entire Practice ☐ Individual Physician (s)

Acknowledgement

Please acknowledge that you have read and understand the terms and conditions above by signing and dating below where provided.

Physician Signature: ________________________________ **Date:** ______________

(No stamps or facsimiles)



Please fax to: 361-561-3028 Attn: IT Department