ASSOCIATION OF ALEXANDRIA RADIOLOGISTS, PC

Complete one agreement for each user and fax to 703-321-3300.

Acknowledgement of Access and Confidentiality Statement

AAR has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of a patient's protected health information. As an authorized user of the AAR PACS program, you have been granted access to protected patient information that is confidential. You are responsible for protecting your User Name and Password and keeping these identifiers secret and protected against loss or theft.

In compliance with HIPAA Privacy and Security Regulations, AAR tracks and records individual user access to patient records. If an unauthorized person knows your User Name and/or Password, this person can assume your identity and gain access to patient records. Any action taken by unauthorized users will be attributed to you in the system security log. Any breaches in confidentiality will be investigated and may result in the loss of your access to the AAR PACS program.

For your own protection as well as that of AAR and our patients, ALWAYS TAKE THE FOLLOWING PRECAUTIONS:

- Never share your system User Name or Password with anyone or write it down and leave it posted near your computer.
- Do not permit anyone to access the system using your User Name and Password.
- Do not leave images or documents displayed on your screen and walk away. Close each patient record when you have completed your review.
- Use the system's standard log off procedures. Failure to log off properly can create a route into the system that is completely unprotected.
- If you believe someone has learned your password, notify the PACS Support Team to have your password reset at **PACSsupport@alexandriaradiology.com or (703) 824-3240.**

I understand that the User Name and Password issued may be used by me only. I also understand that I may not allow or enable anyone else to use my User Name and Password. I also agree to notify the system administrator immediately in the event I discover someone else has used my access.

I also understand I may share patient information from the AAR program with other care providers involved in a patient's treatment. However, access to patient information is to be on a need to know basis only and should be limited to the minimum necessary for that patient's treatment. I understand I am responsible for limiting and protecting access to any patient information I have been granted access to.

I declare that I have read and understand this Acknowledgement. I have had an opportunity to ask questions and have them answered. I recognize that by breaching this agreement I may cause irreparable injury to AAR, the patient and other health care providers and that my access will be revoked immediately.

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User's Printed Name

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User's Signature Date

Revised 09/08/2015