SOUTHWEST DIAGNOSTIC
IMAGING CENTER

REFERRING PHYSICIAN CONFIDENTIALITY AGREEMENT

Today's date: ________________ Physician Name______________________________________
Please print

This document is confirmation to Southwest Diagnostic Imaging Center (SWDIC) and Texas Health Resources (THR) that I am fully aware of the implications of access to the computer systems at SWDIC and THR, and the confidentiality of the information to which I have access.

I understand I must have a Caregate username and password to access the SWDIC PACS system.

I understand that my sign-on I.D. is the equivalent of my legal signature and I will be accountable for all work done under my sign-on I.D.

I understand that the electronic data and information stored in the computer systems are confidential patient, organizational, and practitioner data or information and must be treated with the same care as data and information in the paper records.

I will not disclose my sign-on I.D. and password to anyone, nor will I attempt to learn another person's sign-on I.D. and password. In return, SWDIC will not release my username to anyone.

I will not access data for which I have no responsibilities nor have a "need to know."

If I believe the security of my password has been compromised, I will immediately contact the THR Help Desk at (214) 345- HELP to have my password changed.

I understand the misuse of my access to the THR computer systems and/or misuse of confidential information as outlined by HIPAA, may subject me to denial of access to the SWDIC PACS system.

Network Username:____
Please print

Physician signature:____

Please fax back to 214-345-4885
ATTN: L.J.