PACS CONFIDENTIALITY AGREEMENT

I accept full responsibility for the personal identification (User-Id) and password codes provided to me for access to Fraser Coast Radiology's Picture Archival and Communication System (FCR PACS). To ensure the confidentiality of the information (including personal information) to which I will have access as a user of FCR PACS, I agree that:

1. FCR PACS facilities are to be used for authorized patient treatment purposes only.
2. I will not attempt to access information in the FCR PACS which is not required for my day to day responsibilities. (Browsing patient records or accessing record which are not required is strictly prohibited.)
3. I acknowledge that the personal identification (User-Id) and password codes provided to me are for my use only. I undertake to take all reasonable precautions to protect the privileges provided to me.
4. I will not directly or indirectly permit any other person to access or alter information in the FCR PACS using my personal identification (User-Id) and password codes.
5. I will not attempt to alter information in the FCR PACS.
6. I acknowledge that it is my responsibility to report any incidence of improper and/or illegal use of FCR PACS using my personal identification (User-Id) and password codes to Fraser Coast Radiology immediately that I become aware of any such occurrence.
7. I acknowledge that I am aware of and accept my responsibility for respecting patient privacy and protecting the confidentiality of information available to me as a consequence of my access to FCR PACS and will comply with all relevant privacy laws and codes including, but not limited to, the Commonwealth Privacy Act1988.
8. I indemnify Fraser Coast Radiology from all losses, damages, actions, claims, costs or expenses which may be brought against Fraser Coast Radiology, whether jointly or severally, as a direct or indirect result of my failing to comply with any of the terms or conditions set out above.

Signature: _____ Full Name: _____ Date: __/__/__.

Position Description: _____ Provider Number: _____

Postal Address: _____

Phone: _____ Fax: _____