Southern Arizona Rad Associates
d/b/a Sierra Vista Diagnostics
155 Calle Portal Suite 500
Sierra Vista, Arizona 85635
520-459-5227 (ph) 520-459-2191 (f)
www.svdrads.com

Southern Arizona Rad Associates ("SARA") d/b/a Sierra Vista Diagnostics PHI and EPHI Access Authorization

SARA grants the following healthcare providers and their respective authorized owners, employees, agents, independent contractors and business associates ("Authorized Persons") access to SARA's patient reports/images or both, Electronic Protected Health Information ("EPHI") through an authorized network connection, with the express understanding that the access is necessary to perform treatment, payment, and/or healthcare operations activities and that the undersigned healthcare provider and its Authorized Persons will safeguard the security and confidentiality of the Protected Health Information (PHI) and EPHI in accordance with the health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, including the Privacy Standards and Security Standards implementing such Acts, and other relevant State and Federal laws. It is further understood that it is the healthcare provider's responsibility to ensure that it has complied with all requirements of HIPAA and HITECH to provide its Authorized persons with this access and that all of its Authorized Persons abide by SARA's PHI confidentiality and security requirements, including but not limited to the following: *(a) passwords are not to be shared, (b) all patient searches must utilize at least one (1) other patient identifier in addition to the patient's first and last name, and (c) user names and passwords are not to be stored on any computer or remote access device that would permit automatic login if the machine is lost or stolen.* SARA monitors user activity on a regular basis. User log-ins that are inactive for four (4) months in the case of a licensed healthcare provider or two (2) months in the case of other staff will be deactivated. SARA will attempt to contact users prior to deactivation.

The undersigned healthcare provider and its Authorized Persons expressly agree to limit their access to and use of SARA's patient reports/images database and network connection for their treatment, payment, or health care operations (such as quality assurance, peer review, and so forth) purposes. The undersigned further acknowledges that accessing PHI and EPHI without authorization, accessing or using PHI or EPHI for an improper purpose, or allowing access to PHI or EPHI by unauthorized persons constitutes a HIPAA Privacy and Security Rule violation that could result in the loss of the undersigned's privilege to access SARA's PHI and EPHI, possible criminal prosecution, and other sanctions and such unauthorized conduct may be reportable to law enforcement, professional licensure and disciplinary authorities and the Department of Health and Human Services. The undersigned healthcare provider on behalf of itself and its Authorized Persons further agrees to take all reasonable measures and precautions to ensure that the access to SARA's PHI and EPHI is only available during regular business hours. The undersigned healthcare provider shall immediately notify SARA in the event it becomes aware of any unauthorized access to SARA's PHI, EPHO, or network connection or when any previously Authorized Person is no longer associated with the undersigned so that such Authorized Person's access may be terminated. SARA reserves the right to audit all access to ensure compliance with applicable State and Federal law.

Regarding any network connection established with SARA, the undersigned agrees that it will (i) not knowingly introduce or cause to be introduced into SARA's systems, hardware, software or databases any code, virus, worm, Trojan Horse or other mechanism to disable, adversely affect, harm, or grant unauthorized access or use of any systems, hardware, software or database of the other party; and (ii) maintain reasonable measures to detect and contain such code, virus, worm, Trojan Horse or other mechanisms and to eliminate them from its systems. The undersigned shall: (i) repair or apply applicable security patches to known security vulnerabilities as soon as possible, test and verify that the patches work, and notify SARA immediately of the need for such patches; (iii) use industry standard encryption algorithms and best practice configurations to ensure security of the EPHI transmissions; and (iv) notify SARA immediately of any changes in password policy or changes in the information provided to SARA as part of the network connection authorization process. SARA reserves the right to terminate any network connection in its sole discretion.

Availability of online images cannot be guaranteed due to potential technical difficulties, which may be beyond the control of SARA. It is essential that any images required for surgery or other invasive procedures be obtained in hard-copy form. It is the responsibility of the physician performing these procedures to obtain CD, paper or film copies of the necessary images in advance.

In no event will SARA be liable to the undersigned or its Authorized Persons for any special, indirect, incidental, punitive or consequential damages (including loss of use, data, business or profits) arising out of or in connection with the network connection provided to SARA, including but not limited to, any damages resulting from any delay, omission or error in the electronic transmission or receipt of data from SARA, whether such liability arises from any claim based upon contract, warranty, tort (including negligence), product liability or otherwise, and whether or not the undersigned or its Authorized Persons has been advised of the possibility of such loss or damage.

Sept 2015

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System Access requested for: Network Connectivity ❑

Type of Affiliation with SARA: Hospital Staff ❑ Referring Provider ❑
Other (i.e., Agent, Contractor or Business Associate) ❑

Type of access action to be taken: ADD ❑ CHANGE ❑ DELETE ❑

TO BE COMPLETED BY THE HEALTHCARE PROVIDER AND AUTHORIZED PERSON (USER):

Hospital or Practice Name:____

Hospital ID (if applicable):____

Name of Authorized Person (User): ____

Authorized Person (User) E-mail: ____

Signature of Authorized Person (User): ____Date: ______________

(User affirms that he / she has completed HIPAA training.)

IMPORTANT! IF THE AUTHORIZED PERSON (USER) IS NOT A LICENSED HEALTHCARE PROVIDER, THE BOTTOM SECTION MUST BE COMPLETED BY AN OFFICE MANAGER, ADMINISTRATOR, OR OTHER AUTHORIZED REPRESENTATIVE OF THE HOSPITAL OR PRACTICE

Healthcare Provider Responsible Contact's Name: ____

Responsible Contact's Job Title (i.e. Physician, Administrator, or Office Manager):_________________________

Responsible Contact's Office Address:____

Responsible Contact's Telephone: ____

Responsible Contact's Email: ____

Responsible Contact's Signature: ____Date: ______________

(Responsible Contact affirms that the Authorized Person (User) has completed HIPAA training.)

Please fax completed form to (520) 459-2191
Kelly Baldwin, HIPAA Privacy / Security Officer