Universal Medical Imaging

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Request for UMI Visage PACS Referrer Access

As a referring doctor to Universal Medical Imaging you have been granted access to medical images and reports via our referrer portal. This system is provided to facilitate and expedite the distribution of diagnostic imaging and radiological reports for the care of and treatment of our patients.

Your principal obligations in regard to confidentiality and access to the Universal Medical Imaging referrer portal are explained below. You hereby agree to read and to abide by these duties.

As a condition of your access to confidential information, you understand and agree that:

1. You will use Confidential Information only as needed to perform your legitimate duties as a referring doctor for purposes of treatment of the referred patient.
2. You will only access Confidential Information of the patient for which you have a need to know for care of the patient.
3. You will not misuse or copy confidential information, or act in a careless fashion such that confidential information may be inadvertently disclosed.
4. You will safeguard your Login passcode that allows you to access the system. You may authorise your employees to access information on your behalf, but you then agree to implement agreements and procedures that require your employees to adhere to the provisions stipulated in this agreement and accept responsibility for all activities undertaken using your access code and other authorisation.
5. You will report activities by any individual or entity that you suspect may inappropriately disclose or otherwise jeopardise the confidentiality of, or misuse any confidential information.
6. Access to the system is subject to periodic review, revision and if appropriate renewal, limitation or termination and that Universal Medical Imaging may at any time revoke your access to the system.
7. You understand and agree that your obligations under this Agreement will continue after termination of your access to the Universal Medical Imaging referrer portal.

PLEASE PRINT CLEARLY COMPLETING ALL FIELDS and return to marketing@umic.com.au

Physician Name: _____

Provider Number: _____ **Phone number:** _____

E-mail:_____

GP ☐ Specialist ☐ Registrar ☐ Other ☐ Name Speciality: _____

Canberra Hospital ☐ Calvary Hospital ☐ Hospital Department / Ward: _____

Clinic Name: _____

Physician Signature: _____ **Date:** _____ / _____ / _____