RENAISSANCE IMAGING CENTERS

Web Portal User Access & HIPAA Agreement

Renaissance Imaging Medical Associates and Renaissance Imaging Centers are pleased to introduce our new web based imaging portal.The new portal is located at https://vueportal.rimarad.com/portal/Login.aspx As a valued referring clinician, this gives you Internet capability to; online scheduling, access to your patients' diagnostic imaging procedures including reports and the availability of 'live chat' which can provide assistance from any of our Radiologists and/or clerical staff. By simply obtaining a unique user name and password, we are confident that you will find access to our new portal exceptionally easy and straightforward.

When using the Renaissance Web Portal to transmit health information about an individual patient, federal and state laws require that Renaissance Imaging take appropriate steps to protect against the unauthorized use and disclosure of such information. The Health Insurance Portability and Accountability Act ("HIPAA") allows health information concerning individual patients to be disclosed to another health care provider for purposes relating to the medical treatment of the patient. As you are well aware, as Providers, we are required by HIPAA to safeguard this information. To assure this protection of patients' protected health information from unauthorized use or disclosure, we ask that you agree to the following conditions:

ACCOUNT AGREEMENT:
I understand that no Confidential Information may be accessed, discussed or released without having the proper authorization to do so. Any access, discussions or release of Confidential Information shall only be for purposes of patient care and/or client business and shall be on a "need to know" basis (ie. in order to carry out the duties necessary for services provided to the clients). Access shall also be limited to the "minimum necessary" information to achieve the purpose of the access. Access, disclosure or release includes, without limitation, the access of any electronic or paper-based Confidential Information. I further understand that I will be issued a unique Username and Password which I will be responsible for. If I discover that the confidentiality of the Password has been compromised, I will change it immediately and promptly notify the Director of Operations, Claudia Kazanjian, at Renaissance Imaging. By indicating my signature below, I attest that I have reviewed and understand the foregoing statements and agree to be bound by the terms and conditions herein and the relevant policies and procedures regarding system access and confidentiality, and that any failure on my part to comply with the terms set forth herein and in such polices will be reported to my supervisor and may subject me to disciplinary action which may include immediate termination of my web portal account(s).

USE AND SAFEGUARDING OF PASSWORDS:
I understand that passwords are used to ensure that access to the Renaissance Imaging information systems is limited to authorized individuals. I agree to abide by the following rules governing the use of passwords:
1) Passwords must be at least six alpha or numeric characters in length. 2) Passwords must not consist of my name or the word "Password". 3) Passwords must not be written down or contained in a file located

on your computer. 4) Passwords must not be disclosed to any person outside the office/company. 5) Passwords must not be transmitted on-line, especially by e-mail. **6) Passwords should be changed every 90 days. 7**) I will notify Renaissance Imaging when any authorized user of the web portal account is no longer employed with the practice.

Renaissance Imaging Medical Associates and Renaissance Imaging Centers reserves the right to terminate this agreement and your participation with https://vueportal.rimarad.com/portal/Login.aspx upon making a determination that there has been a violation or breach of any of the terms and conditions of this agreement.

ACKNOWLEDGEMENT:
Please acknowledge that you have read and understand the terms and conditions above by signing and dating below where provided.

ALL fields must be complete or the request will be returned. Please PRINT clearly.

Last Name: _____ **First Name:** _____

Office Address: _____

Group Name: _____

Email: _____ **Telephone Number:** _____

Renaissance Referral Locations (The RIMA locations your patients have imaging done**.** Circle all that apply)**:** Downtown Los Angeles, Wilshire Location, Northridge, Westlake Village, Van Nuys, None

Referring Physicians (full names): _____

Referring Physicians (full names): _____

Referring Physicians (full names): _____

Referring Physicians (full names): _____

Referring Physicians (full names): _____

Signature: _____ **Date:** _____

Please mail or fax your signed acknowledgement to:
Renaissance Imaging Center at Northridge Hospital
18436 Roscoe Blvd. Northridge, California 91328
(818) 435-1400 or Fax: 855-551-6834