

**IS_FM_0006 - Request for Access to Fulford Radiology Services Ltd (FRSL)
Image Archive via Meddram WEB or THE REMOTE DESKTOP**

Important Note:

- The information obtained from FRSL WEB PACS is **CONFIDENTIAL**.
- You are responsible and accountable for your password. Please keep your password secure. **DO NOT SHARE YOUR PASSWORD WITH ANY OTHER PERSON.**
- If you think other staff are using your password, **CHANGE IT IMMEDIATELY.**

| | | | |
|--|---|--------------------------|--------------------------|
| First Name*: | | Surname*: | |
| Practice Name*: | | Practice Address*: | |
| Contact Phone*: | (0) | Professional Title*: | |
| Mobile: | (0) | NZMC Number*: | |
| Initials*: | (3 initials required to create user name) | | |
| Email address*: | | | |
| I agree to adhere to the following: | | | |
| My practice adheres to the Rules of the Health Information Privacy Code. | Yes | <input type="checkbox"/> | |
| I will not allow my password to be used by other staff within the practice. | I agree | <input type="checkbox"/> | |
| I agree to limiting the viewing of radiology reports and radiology images to patients that I or the practices within which I work have referred. | I agree | <input type="checkbox"/> | |
| I acknowledge that the image quality is dependant upon the resolution of my own computer systems and is not the responsibility of FRSL. | I Acknowledge | <input type="checkbox"/> | |
| I Acknowledge that I am responsible for ensuring the Remote Desktop connection settings on my device are set to the highest quality possible. | I Acknowledge | <input type="checkbox"/> | |
| I acknowledge that the viewing of JPEG images is not for diagnostic purposes and it is the radiology report that must be used to guide patient management and not the viewing of these images. | I Acknowledge | <input type="checkbox"/> | |
| I acknowledge that failure to adhere to these statements and any other policies that FRSL inform me of will result in my access being revoked. | I Acknowledge | <input type="checkbox"/> | |
| | | | |
| User Signature: | | Date: | |
| Designation: | | | |
| <i>For Office Use Only:</i> | | | |
| Access Granted: | | Yes | <input type="checkbox"/> |
| | | No | <input type="checkbox"/> |
| Date: | | | |
| Date Password Posted: | | | |
| IT Signature: | | | |
| Managing Partner Signature: | | Date: | |

* required information; if not provided access cannot be granted

Please fax this completed form only to:

IT Team
Fulford Radiology Services Ltd
Fax No: (06) 753 7618