Application for Access to PACS System:

ACCESS REQUIRES THAT YOU ARE EITHER:
1) A physician with a valid medical license
2) A non-physician with an authorized need to access the PACS System

Your Name: _____   Title (DO, MD, PA, etc) _____

Organization: _____   Phone _____

Email Address: _____

PLEASE READ CAREFULLY
1) I agree to maintain all patient information confidentiality.
2) I agree to be held personally responsible for the use of my username/password.
3) I agree not to share or disclose my username/password to another user.
4) I agree to close my browser (eg. Explorer or Netscape) when done to prevent
   unauthorized use of my access to PHI.
5) I understand that if I improperly use confidential patient information the PACS Administrator
   will disable my access.
6) I understand that my failure to follow each clause of this agreement will result in
   suspension and/or revocation of PACS access privileges.

You will receive an email when your account has been activated with your username and sign-on password which you will be required to change at sign-on.

Signed: _____

Date: _____

Fax or email your application to the Medical Data Integration (MDI) administrator:
Fax (309) 764-1910
Phone (309)764-MDI1 (6341)
Email: PacsAdmin@mdipacs.com

YOU WILL BE NOTIFIED WHEN YOUR ACCOUNT IS ACTIVE

Medical Data Integration, LLC

"Our Business Is Simplifying Your Business"