

MRI Center of Idaho / MRI Mobile

CONFIDENTIALITY AGREEMENT

To facilitate the treatment of my patients, MRI Center of Idaho is willing to allow me to access protected health information concerning my patients maintained in MRI Center of Idaho's RadConnect/Amicas. As a condition to allowing me such access, I agree to the following:

1. I acknowledge that the RadConnect/Amicas and the records included therein contain confidential health information protected by applicable federal and state law, including but not limited to the HIPAA Privacy and Security Rules, 45 C.F.R. § 164.101 *et seq.* Furthermore, I understand that MRI Center of Idaho owns the RadConnect/Amicas and the records included in the RadConnect/Amicas, and has a proprietary interest in the RadConnect/Amicas and the processes and trade secrets associated with accessing and utilizing the RadConnect/Amicas.

2. I will maintain the confidentiality and security of the protected health information contained in the RadConnect/Amicas consistent with the requirements of federal and state law, including but not limited to the HIPAA Privacy and Security Rules. I will only access the RadConnect/Amicas to obtain protected health information relating to my patients as necessary to provide treatment for my patients. I will not access the RadConnect/Amicas for purposes unrelated to the treatment of my patients, nor will I access protected health information of persons who are not my patients without the express written consent of MRI Center of Idaho.

3. I will maintain the confidentiality of any processes or trade secrets associated with the RadConnect/Amicas. I will not access or use any information relating to the RadConnect/Amicas for any improper purpose, including but not limited to any purpose that may injure or cause damage to MRI Center of Idaho or to gain a competitive advantage against MRI Center of Idaho.

4. I will ensure that any of my employees, agents, representatives, or others acting through my authority who access the RadConnect/Amicas comply with the terms of this Agreement.

Practice Name:(Print) _____

Name:(Print) _____

Signature: _____

Date: _____ Phone _____

Email address: _____ Fax _____

Upon completion, please fax this form to:

208-947-7001

ATTN: Information Technology (IT)