

DO YOU CURRENTLY HAVE AN ACCOUNT TO ACCESS THE SYSTEMS AT NEBRASKA MEDICINE? YES NO

IF YES WHAT IS YOUR USER NAME? _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DOB: _____ LAST 4 OF SSN: _____ EMAIL ADDRESS: _____

CLINIC NAME: _____

CLINIC ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CLINIC PHONE NUMBER: _____ CLINIC MANAGER: _____

This would be the person authorizing.

PLEASE SELECT THE MODALITIES YOU WILL REQUIRE VIEWING ACCESS TO (CHECK ALL THAT APPLY):

- | | | | |
|-----------------------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> ALL MODALITIES | <input type="checkbox"/> CR | <input type="checkbox"/> MG | <input type="checkbox"/> NM |
| <input type="checkbox"/> US | <input type="checkbox"/> CT | <input type="checkbox"/> MR | <input type="checkbox"/> RF |

PLEASE SELECT THE FACILITIES YOU WILL REQUIRE VIEWING ACCESS TO (CHECK ALL THAT APPLY):

- | | | |
|-------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> NEBRASKA MEDICINE | <input type="checkbox"/> NEBRASKA MEDICINE – VILLAGE POINTE | <input type="checkbox"/> LAURITZEN OUTPATIENT CENTER |
| <input type="checkbox"/> NEBRASKA MEDICINE – BELLEVUE | <input type="checkbox"/> NEBRASKA MEDICINE – CLINICS | |

The Radiology Outreach Portal may be used to access information to provide treatment for current patients or to evaluate the need for treatment to a current patient ONLY.

Users are responsible and accountable for all access under their personal accounts. Logins MAY NOT be shared with other users. Access to the Radiology Outreach Portal is audited. Questionable or impermissible access may result in termination of access to the portal and other patient information systems.

By logging into the Radiology Outreach Portal, you agree to comply with these terms and conditions AND that you are responsible for the privacy of those records you access.

The Clinic Manager will be responsible for notifying the Nebraska Medicine Radiology Department of any users that separate from your clinic.

USER SIGNATURE: _____ DATE: _____

AUTHORIZED BY (CLINIC MANAGER): _____ DATE: _____

**SUBMISSION
INFORMATION**

Please fax completed form to 402.559.1011 or email PACSAccess@NebraskaMed.com.