PACS
User Maintenance Form

To avoid delay, please print legibly.

Practice Name: _____
Provide full name of practice / No abbreviation please

Provider Name(s): _____

Office Address: _____

CITY: _____ ZIP: _____

Primary Office Contact: _____

Primary Office Contact Email: _____

Office Phone: (_____) _____-_____

Fax to Christie McCarty at (813) 518 - 4371 or

Email to CSMcCarty@TowerRadiologyCenters.com

Marketing Rep: _____

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

SCHEDULE A
Authorized Users

Marketing Rep Phone: (_____) _____-_____

The following individuals are designated by the Provider to Access and use the Platform on behalf of the

Provider: _____ (Provider or Practice Name)

Office Address: _____

Marketing Rep: _____

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EACH PHYSICIAN AND STAFF MEMBER MUST COMPLETE THIS FORM IN ORDER TO BE ISSUED A USERNAME & PASSWORD

❑ Enroll ❑ Terminate

Print First Name: _____ Print Last Name: _____ Title: _____

NPI if applicable: _____ UPIN if applicable: _____

Email address (work): _____@_____

Signature: _____ Date: _____

❑ Enroll ❑ Terminate

Print First Name: _____ Print Last Name: _____ Title: _____

NPI if applicable: _____ UPIN if applicable: _____

Email address (work): _____@_____

Signature: _____ Date: _____

❑ Enroll ❑ Terminate

Print First Name: _____ Print Last Name: _____ Title: _____

NPI if applicable: _____ UPIN if applicable: _____

Email address (work): _____@_____

Signature: _____ Date: _____

❑ Enroll ❑ Terminate

Print First Name: _____ Print Last Name: _____ Title: _____

NPI if applicable: _____ UPIN if applicable: _____

Email address (work): _____@_____

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SCHEDULE A
Authorized Users

Signature: _____ Date: _____

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