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Government of South Australia
SA Health

SOUTH AUSTRALIA MEDICAL IMAGING

SAMI-FOR-040

SAMIView - EXTERNAL REFERRER ACCESS FORM

Practice Details	
Practice Name:	
Practice Manager or Contact:	
Business Address:	
Postal Address:	
Contact Phone Number:	
Fax Number:	
Practice Email:	

Individual Referrer Details	
Referrer First Name:	
Referrer Last Name:	
Medicare Provider Number:	
AHPRA Registration Number:	
Qualification:	
Mobile Phone Number: **(Required for direct contact)**	
Email:	
Do you have an active SA Health ID (HAD ID)?	

**** Please note all fields on this form are mandatory ****

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SA Health

SOUTH AUSTRALIA MEDICAL IMAGING

Confidentiality Agreement

I acknowledge I will be granted access by the Central Adelaide Local Health Network Inc (acting through South Australia Medical Imaging) (SAMI) to SAMIView in order to view, print, and download patient diagnostic images and reports (Confidential Information).

My access to and use of any Confidential Information stored on SAMIView will be bound by and subject to the following terms and conditions:

(a) I hereby undertake to maintain the confidentiality of the Confidential Information at all times;
(b) I hereby undertake not to use the Confidential Information in any way which would be harmful to the best interests of SAMI;
(c) I agree that I must comply with the South Australian Government Information Privacy Principles (a copy of which can be found at http://www.dpc.sa.gov.au/documents/rendition/B17711#sthash.s76QhRX6.dpuf) ("**IPPs**") as if I were an "agency" for the purposes of the IPPs, in relation to all Confidential Information that I view, print or download from SAMIView;
(d) I agree that I must comply with the *Privacy Act 1988* (Cth) and the Australian Privacy Principles under that Act as if I were an "agency" for the purposes of that Act, in relation to all Confidential Information that I view, print or download from SAMIView;
(e) I agree that I must not allow or otherwise cause my username and/or password for access to SAMIView to be used by, or obtained by, any other person; and
(f) I agree that I must promptly notify SAMI if I fail to comply with these terms and conditions or if I become aware of any actual or threatened disclosure of or unauthorised access to the Confidential Information.

I hereby indemnify SAMI, its officers, employees, contractors and agents at all times from and against any claim, action, suit, damage, cost, loss, expense or liability of any kind (whether in contract, tort or otherwise) including all legal costs on a full indemnity basis (howsoever suffered or incurred) directly or indirectly suffered or incurred by SAMI as a result of or in connection with any breach or failure by me to comply with the above terms and conditions.

Clinician Access

******Please tick one box for required access & sign and date form******

☐ **LIMITED ACCESS:** I acknowledge that I will only access images and reports for patients that I have referred for imaging.

☐ **OPEN ACCESS**: I acknowledge that I am generally not a primary referrer and therefore I request unlimited access to patient diagnostic image and reports.

Signature: _____ **Date:** _____

******MANDATORY SIGNATURE REQUIRED******

Please email completed form to Health.SAMIReferrerSupport@sa.gov.au

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