Advanced Radiology Services P.C.
3264 North Evergreen Dr. NE
Grand Rapids, MI 49525

Intelerad User Access Request – new users please fill out this portion only

_____ _____
User Name (Last, first, middle initial) Date

_____ _____
Credentials (M.D., D.O., RT (R)) Role

_____ _____ _____
Primary Fax Primary Phone E-mail address

_____ _____ _____
Group affiliated with (if applicable) RIS ID NPI Number

Type of Request

☐ New account ☐ Remove account

Programs User Will Need Access To

☐ Inteleviewer ☐ Intelebrowser ☐ Citrix

Verification of Rights to Patient Information

☐ By signing below, the authorized representative of Bronson South Haven verifies the person listed above has met the criteria and requirements for access to patient records of Bronson South Haven including executing a confidentiality agreement in compliance with applicable laws.

Authorized Hospital Representative Name (Print) _____

Signature _____ Date _____

- Accounts not used for periods of greater than three months may be disabled at the discretion of ARS without notice.

- It is the responsibility of the requesting organization to inform ARS of the departure of any employees from that organization.

For Administrative Use Only: Date received _____

Action taken _____

_____ Date _____

Action taken _____

_____ Date _____

Security Administrator signature_____ Date _____