Center for Integrated Health Care

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**Notice of Electronic Health Communications Privacy Policies**

**and Release Authorization**

This notice serves to inform you of how your protected health information (PHI) is used and disclosed upon your authorization to receive electronic health information through The Practice Fusion Patient Health record Portal (PHR).

**Use and Disclosure of Protected Health Information (PHI)**

Protected Health Information (“PHI”) may not be used or disclosed in violation of the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rule (45 C.F.R. parts 160 and 164) (heinafter, the “Privacy Rule”) or in violation of state law.

Upon signing this authorization for either your consent or refusal of release of your PHI through our PHR, your rights are as follows:

Your PHI will ONLY be disclosed to YOU via Practice Fusion’s secure Patient Health Record portal through the email addressed provided and verified by you during the set-up process. You may view Practice Fusion’s security statement by visiting [www.PracticeFusion.com](http://www.PracticeFusion.com). At any point, if you would like to un-enroll in the PHR, you may notify our staff in writing, and we will remove the authorization from your account.

Your PHI transmitted through the PHR will never be sold, used or disclosed for any other purpose than for your personal use. We will never utilize the PHR for third-party marketing purposes.

Benefits of the PHR portal: electronic access to lab results, messaging system to communicate with the physician, appointment request tool, list of past and upcoming appointments, and reminders for upcoming appointments.

\_\_\_\_\_\_\_ **YES**, I give my permission for CIHC’s staff to enroll me in the Patient Health Record Portal so that I may view my personal health information. I understand that the transmission of this information is securely sent through an email address that I provide and will verify during the set-up process.

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ **NO**, I do not give my authorization to participate in the Patient Health Record. I understand that I will not have access to my personal health information via the Patient Portal. I also understand that should I decide at a later date to enroll, I may do so.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_