PHOENIX HEALTHCARE OF ASHEVILLE, PLLC
2149 Riceville Rd., Asheville, NC 28805
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _________________________, (self, parent or legal guardian of____________) understand that as part of (my, my child) healthcare, Phoenix HealthCare of Asheville, PLLC originates and maintains paper and /or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment records, and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my or my child's health care and treatment
- A means of communication among mental health professionals who contribute to my or my child's care
- A source of information for applying diagnosis and mental health information to the bill
- A means by which third-party payers can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with electronic ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Phoenix HealthCare of Asheville, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken reliance thereon. I also understand that by refusing to sign this consent or revoking the consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose (my, my child's) protected health information to another entity, and I consent to such disclosure for those permitted uses, including disclosures via fax.

I further understand that Phoenix HealthCare of Asheville, PLLC reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that Phoenix HealthCare of Asheville, PLLC will send a copy of any revised notice to the e-mail or street address listed below:
Address:____
I wish to have the following restrictions to the use or disclosure of (my, my child's) health information:

____

I fully understand and _____accept _____decline the terms of this consent.
Signature____________________________ Date_____________________________