CARROLL R. BUTLER, D.D.S.

321 West Water Street
Kerrville, Texas 78028

Phone: 830/257-4900

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I understand that as part of my health care, Carroll R. Butler, DDS originates and maintains medical records describing my health history, symptoms, examinations and test results, diagnoses, treatment, financial and demographic information, as well as any plans for future care of treatment. Physician also originates and maintains billing records, I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between Dr. Butler and health care professionals that act under the direction of Physicians and participate in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting health care operations, including: the evaluation of health care services, appropriateness and quality of health care treatment, and the qualifications of health care practitioners.

I have been provided with a copy of Physician's *Notice of Privacy Practices* that provides information about how Carroll R. Butler, DDS uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. Dr. Butler is not required to agree to requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the Notice may change. If they do, I may obtain a revised copy from Carroll R. Butler, DDS by calling 830/257-4900. I understand that I may revoke this consent in writing, except to the extent that Carroll R. Butler, DDS has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, Dr. Butler may refuse to treat me.

I ask that, in addition to the purposes stated above, my confidential information may be released to the following individuals: (Example: spouse, children, caregiver) _____

_____.

_____ _____
Signature of Patient or Representative Date

_____ _____
Patient Name Patient Date of Birth

_____ _____
Name of Representative (if applicable) Relationship

For Office Use Only

Restrictions to use and disclose of health information ___Accepted ___Denied

_____ _____
Signature of Dr. Butler Date

[ ] Consent refused by patient, refusal given on _____ to _____(initial)