DR. JAMES C. WALKER, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND IDENTITY THEFT PROTECTION

_____ _____

PRINT Patients Name **Patients Date of Birth**

I have been presented with a copy of Dr. James C. Walker's Notice of Privacy Policies, which details how my information may be used and declared and permitted under federal and state law. I understand the contents of the Notice and that my health information may be used for treatment, payment and health operations.

I understand that photographs, or other images may be recorded to document my care and my identity, and I consent to this. I understand that **Dr. James C. Walker, M.D.** will retain the ownership rights to these photographs or other images, but that I will be allowed to access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Dr. James C. Walker, M.D. policy. Images that identify me will be released and/or used outside the institution only upon written authorization from my legal representative or me.

With regards to communications with my family or friends, **Dr. James C. Walker, M.D.**, will not discuss or release any of my health information to any of my family members or friends unless that family member is my legal representative or is named below.

Family Member/Friend Name and Relationship to patient:

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

If the patient is a minor child, **Dr. James C. Walker, M.D.** will disclose his/her health information only to the mother and/or father of the child.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party accepting assignment. Regulations pertaining to medical assignment of benefits apply.

_____

Signature of Patient or Legal Representative

_____

Relationship to Patient

_____

Date

****

( ) Patient refused to sign acknowledgment:

_____ _____

Date

Signature of Dr. James C. Walker, M.D. Representative