Walker Eye Care

William M. Walker, O. D.
971 S Cox St
Asheboro, NC 27203

Acknowledgement of Receipt of Privacy Notice

I, (Patients name)_______________________________________ have been presented with a copy of the Walker Eye Care Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical
information:____
____
____

Further, 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 the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: ____

Date: ____

If not signed by patient, please indicate relationship to the patient (e.g., spouse, child)

Relationship: ____

Witnessed by: ____

Date: ____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: ____ (date & time)

By: ____ (name & title)