John D. Bertrand
M.D., F.A.C.O.G.

David M. Bookout
M.D., F.A.C.O.G.

Jane E. Nokleberg
M.D., F.A.C.O.G.

James K. Richards
M.D., F.A.C.O.G.

Julie M. Hagood
M.D., F.A.C.O.G.

Jeffrey M. Thurston
M.D., F.A.C.O.G.

Hampton B. Richards
M.D., F.A.C.O.G.

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

______________________________ ______________

Patient Name **Date**

I understand that under the Helath Insurance Portability and Accountablity Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Walnut Hill OB/GYN may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient handling billing and payment; and , taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Walnut Hill OB/GYN has a detailed document called the ***"NOTICE OF PRIVACY PRACTICES".*** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Walnut Hill OB/GYN will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the cance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Walnut Hill OB/GYN to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Walnut Hill OB/GYN has taken action relying on this consent.

______________________________ ______________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

______________________________ ______________

RELATIONSHIP TO PATIENT if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices,* including any revisions of our '*Notice*' at any time by contacting: Walnut Hill OB/GYN Associates @ 214-363-7801.

John D. Bertrand
M.D., F.A.C.O.G.

James K. Richards
M.D., F.A.C.O.G.

Jeffrey M. Thurston
M.D., F.A.C.O.G.

Jane E. Nokleberg
M.D., F.A.C.O.G.

Julie M. Hagood
M.D., F.A.C.O.G.

David M. Bookout
M.D., F.A.C.O.G.

Hampton B. Richards
M.D., F.A.C.O.G.

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name: ______________________________ Date: __________

☐ Check here if minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical text books or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medial care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

____

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   ______________________ ______________________
   (Signature) (Witness)

2) I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publication.

   ______________________ ______________________
   (Signature) (Witness)

3) I agree to the use of my image for my medical records **ONLY**:

   ______________________ ______________________
   (Signature) (Witness)