

Acknowledgment Of Receipt
of
“NOTICE OF PRIVACY PRACTICES”
for
Protected Health Information

I, acknowledge that I have received a copy of WellStar Health System's "Notice of Privacy Practices" for Protected Health Information on the date set forth below.

Date of Receipt

Patient Name

Print Name of Authorized Personal Representative

Signature of Patient

Signature of Authorized Personal Representative

Please Indicate Relationship to Patient

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY: *[Complete if patient Acknowledgment is not obtained]*

An Acknowledgment of Receipt of Notice of Privacy Practices was not obtained because:

- Patient refused to sign Acknowledgment.
- Unable to gain signed Acknowledgment due to communication/language or other barrier.
- Patient was unable to sign Acknowledgment due to emergency treatment situation.
- Other: *Please indicate reason* _____

Signature of WellStar Representative: _____ Date: _____

Please *the appropriate facility:*

- Kennestone Hospital Cobb Hospital Douglas Hospital Windy Hill Hospital Paulding Hospital
- Homecare Hospice
- Physician's Group: _____ Other: _____