

WellStar Health System
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**

MR # **Signature of Patient**

Printed Name and Signature of Authorized **Relationship to Patient**
Personal Representative

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 check the appropriate facility:

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