WELLSTAR Medical Group

Acknowledgment of Receipt

"NOTICE OF PRIVACY PRACTICES"

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 Date of Birth

Print Patient Name

Print Name of Authorized Personal Representative

Patient Signature

Signature of Authorized Personal Representative

Please indicate relationship to patient

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY

*(complete if patient acknowledgement is **not** obtained)*

An Acknowledgment of Receipt of Notice of Privacy Practices was not received 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

WellStar Medical Group

Acknowledgment of Receipt of Notice of Privacy Practices