

**Westside Medical Associates
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Acknowledgement of Receipt
of
“NOTICE OF PRIVACY PRACTICES”
for
Protected Health Information

I, acknowledge that I have received a copy of WESTSIDE MEDICAL ASSOCIATES
“Notice of Privacy Practices” for Protected Health Information on the date set forth
below.

Patient Name

Date of Receipt

Print Name of Authorized Personal
Representative

Signature of Authorized Personal
Representative

Please Indicate Relationship to Patient

FOR USE BY WESTSIDE MEDICAL ASSOC. PERSONNEL ONLY: (Complete if Patient Acknowledgement is not obtained)

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

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

Signature of WESTSIDE MEDICAL ASSOCIATES Representative: _____