

**Westside Medical Associates**  
**Jasmine Jeffers, MD**  
**Lisa Dillard, MD**

**Austell Office**

3825 Medical Park Drive SW  
Suite 300  
Austell, Georgia 30106 - 1109

Phone: 770-941-4810

Fax: 770-948-9149

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.

<hr/>	<hr/>
Patient Name	Date of Receipt
<hr/>	<hr/>
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: \_\_\_\_\_