WELLSTAR Physicians Group

Patient Name_____ Date of Birth_____

Acknowledgement 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.

- Permission is given to leave medical information in the specified manner and to the specified person(s)

____ You may leave messages on my home answering machine

____ You may call my work number

____ You may leave messages on my office voice mail.

____ You may leave messages on my cell phone voice mail _____

____ You may share medical and account information with my spouse._____

____ You may share medical and account information with my children._____

____ You may only give information to no one but myself.

____ You may share medical and account information with _____

Special requests and limitations

- Pediatric Proxy Permission Form: The following person(s) may make medical decisions and sign any appropriate documents related to my child's care in my absence.

Name of Proxy Relationship

_____

_____

_____

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient