

## Notice of Privacy Practices Acknowledgment

The Joint Notice of Privacy Practices brochure describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns or complaints.

We have a responsibility to protect the privacy of your information, provide a Notice of Privacy Practices and follow the information practices that are described in this notice. If you have any questions, please contact: UW Medicine Compliance **855-211-6193** (*toll free*).

We may change our policies at any time. Any significant policy change will be posted.

You may request a copy of this notice from UW Medicine Compliance 855-211-6193 or at [www.uwmedicine.org/nopp](http://www.uwmedicine.org/nopp).

**By signing below, I agree that I have received the Joint Notice of Privacy Practices.**

SIGNATURE ( <i>PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE</i> )	PRINT NAME	DATE	TIME
<b>IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:</b>			
<input type="checkbox"/> 1. Court-appointed Guardian	<input type="checkbox"/> 2. Durable Healthcare Power of Attorney	<input type="checkbox"/> 3. Spouse/registered domestic partner	
<input type="checkbox"/> 4. Adult Child(ren)	<input type="checkbox"/> 5. Parent(s)	<input type="checkbox"/> 6. Adult Brother(s)/Sister(s)	
<input type="checkbox"/> 7. Adult Grandchild(ren)	<input type="checkbox"/> 8. Adult Niece(s)/Nephew(s)		
<input type="checkbox"/> 9. Adult Aunt(s)/Uncle(s)	<input type="checkbox"/> 10. Adult Friend with executed Declaration per RCW 7.70.065		
<b>FOR MINOR PATIENTS:</b>			
<input type="checkbox"/> 1. Guardian/legal custodian	<input type="checkbox"/> 2. Court-authorized person for child in out-of-home placement	<input type="checkbox"/> 3. Parent(s)	
<input type="checkbox"/> 4. Holder of signed authorization from parent(s) <input type="checkbox"/> 5. Adult representing self to be a relative responsible for the minor's health			
WITNESS SIGNATURE ( <i>WITNESS OPTIONAL UNLESS TELEPHONE CONSENT</i> )	PRINT NAME	<input type="checkbox"/> TELEPHONE MONITORED CONSENT <i>(No patient signature)</i>	

**FOR OFFICE USE ONLY: REMARKS for the UW Medicine Notice of Privacy Practices:  
(This section below is to be filled out by UW Medicine staff only)**

*We are unable to obtain acknowledgment from this individual at this time, but immediate treatment is needed for the following reason(s):*

- Emergency Treatment Situation*
- Incarcerated Patient*
- Patient refuses to sign*
- Patient unable to sign*

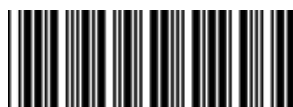
PLACE PATIENT LABEL HERE

**UW Medicine**

Harborview Medical Center – University of Washington Medical Center  
UW Medicine Primary Care – Valley Medical Center – UW Physicians

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

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WHITE – MEDICAL RECORD  
YELLOW - PATIENT