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.

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

SIGNATURE *(PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)*	**PRINT NAME**	**DATE**	**TIME**

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ **1.** Court-appointed Guardian ☐ **2.** Durable Healthcare Power of Attorney ☐ **3.** Spouse/registered domestic partner
☐ **4.** Adult Child(ren) ☐ **5.** Parent(s) ☐ **6.** Adult Brother(s)/Sister(s)
☐ **7**. Adult Grandchild(ren) ☐ **8**. Adult Niece(s)/Nephew(s)
☐ **9**. Adult Aunt(s)/Uncle(s) ☐ **10**. Adult Friend with executed Declaration per RCW 7.70.065

FOR MINOR PATIENTS:

☐ **1.** Guardian/legal custodian ☐ **2.** Court-authorized person for child in out-of-home placement ☐ **3.** Parent(s)
☐ **4.** Holder of signed authorization from parent(s) ☐ **5.** Adult representing self to be a relative responsible for the minor's health

WITNESS SIGNATURE *(WITNESS OPTIONAL UNLESS TELEPHONE CONSENT)*	PRINT NAME	☐TELEPHONE MONITORED CONSENT *(No patient signature)*

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

U2045

WHITE – MEDICAL RECORD
YELLOW - PATIENT