

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).

Please do not write comments on this form, refer to the "Your Individual Rights About Patient Health Information."

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 PERSON AUTHORIZED TO GIVE AUTHORIZATION)	DATE
IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATIONSHIP TO PATIENT: <input type="checkbox"/> 1. Guardian <input type="checkbox"/> 2. Durable Power of Attorney for Health Care <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) FOR MINOR PATIENTS: <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	

**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*

PT.NO	<div style="border: 1px dashed gray; padding: 10px; text-align: center;">Place EPIC Label Within Box</div>
NAME	
DOB	

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT**



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WHITE – MEDICAL RECORD
YELLOW - PATIENT