

***By signing this document, I acknowledge that I have received a copy of MultiCare Health System's Notice of Privacy Practices (NPP).***

Today's Date \_\_\_\_\_

\_\_\_\_\_  
Patient's Full Name (Print)

\_\_\_\_\_  
Medical Record

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient or Personal Representative's Signature

\_\_\_\_\_  
Personal Representative's Relation to Patient

**MultiCare Health System Use Only**

- Patient required emergent treatment. Was not practical to collect acknowledgment.
- Gave a copy of the NPP to patient and requested their acknowledgment, but patient refused to sign.

Comments: \_\_\_\_\_  
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Processed By (Print)

\_\_\_\_\_  
Today's Date

**Notice of Privacy Practices  
Acknowledgment Form**

