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By signing this form, I acknowledge that I have received a copy of Wind River Oncology's Privacy Practice Notice.

Patient signature (or legal representative)

Date

Print patient name

Legal representative's relationship to patient

A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices. The following identifies the efforts made and the reason the acknowledgment was not obtained.

Signature
Wind River Oncology
Staff Member

Date