Sharona Stone, MEd, LCSW, DCH
6093 S. Quebec St. #200
Centennial, CO 80111
TEL: 303.779.1699
FAX: 303.771.9284
EMAIL: sharona@drsharona.com

RECEIPT OF PRIVACY PRACTICES

Patient's name: _____

Date of birth: _____

Social Security number: _____

_____ Patient refuses to provide social security number.

I hereby acknowledge that I have received and been given an opportunity to read the document provided by Dr. Sharona Stone, informing me of her Privacy Practices. I understand that if I have any questions regarding these practices or my privacy rights, I can contact Sharona Stone at 303.779.1699.

_____ _____
Patient's signature Date

_____ _____
Signature of parent, guardian or personal representative Date

If you are signing as a personal representative of an individual please provide the status of your legal authority i.e., Guardian, Personal Representative, etc.

_____ Patient refuses to acknowledge receipt.

_____ _____
Signature of staff member Date