

HEATHER STONE, PH.D.

Clinical Psychologist, PSY 21112

(707) 291-7386

930 Mendocino Ave.

Suite 203

Santa Rosa, CA 95401

www.drheatherstone.com

**HIPAA RECEIPT
(NOTICE OF PRIVACY PRACTICES)**

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice. I have received information about my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information residing at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient).
