Robin Sakakini, Psy.D.
Licensed Psychologist
PSY 25438

HIPAA NOTICE OF PRIVACY PRACTICES

Child's Name: _____

Child's Date of Birth: _____

By signing below, I acknowledge I have received a copy of my/my child's HIPAA Notice of Privacy Practices from Dr. Robin Sakakini.

Name: _____

Relationship to Child:_____

Name: _____

Relationship to Child:_____

_____ _____
Date Signature of Parent/Guardian

_____ _____
Date Signature of Parent/Guardian

_____ _____
Date Signature of Clinician as Witness