Robin Sakakini, Psy.D.
Licensed Psychologist
PSY 25438

Authorization to Release Information

Patient: _____

Address: _____

I hereby authorize Robin Sakakini, Psy.D. to disclose and/or receive from

_____
(name) (phone #)

information pertaining to my (or my child's) psychological services rendered from:

_____ to _____.

Specific information requested includes: _____

_____

This authorization is good until: _____

This authorization allows Dr. Sakakini to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: _____ Date: _____
(parent, if patient is a minor)

Dr. Sakakini's signature: _____ Date: _____