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**The Rajan Center for Family Wellness LLC**

**HIPPA Acknowledgment**

**By your signature below, you indicate that you have read the document entitled “Notice of Psychiatrists’ Policies and Practices to Protect the Privacy of Your Health Information”**

Patient’s Name (Print):

Signature of Patient (If older than 18):

Date:

***If Patient is under 18 years old:***

Name of Parent/Legal Guardian (Print):

Signature ofParent/Legal Guardian:

Date:

Name of other Parent/Legal Guardian (Print):

Signature of other Parent/Legal Guardian:

Date: