

**LATA SONPAL PHD FCHT., P.A.  
7756 North Kendall Drive, # 496  
Miami, FL 33156-8550**

**RELEASE OF INFORMATION**

I authorize the release of information contained in the records of:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

between the following parties:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

and:

**LATA SONPAL PHD FCHT., P.A.  
7756 North Kendall Drive, # 496  
Miami, FL 33156-8550**

I understand that this consent applies to all psychological, medical, educational, and/or legal information which may be exchanged verbally and/or in writing. A photocopy of this is as valid as an original.

This authorization will be valid until the termination of services in our offices, unless it is revoked in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date