**LATA SONPAL PHD FCHT., P.A.**
**7742 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.**
**7742 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