SOPHIE GUELLATI-SALCEDO Ph.D.
HEALTH PSYCHOLOGIST

Telehealth Practice
Based in Miami, FL 33156
sophie.guellati@gmail.com
Tel. : (305) 799-9970

Authorization for Release of Information

Client Name:_____

Authorization: I hereby authorize

Name of Professional/Organization: _Sophie Guellati-Salcedo, Ph.D_____

Address: __Telehealth Practice_____

_____Miami, FL 33156_____

Telephone:__(305) 799-9970_____ Email Address:_sophie.guellati@gmail.com_

to release psychological, social, and or medical information from the records of the above identified client to:

Name of Professional/Organization: _____

Address: _____

_____

Telephone:_____ Email Address:_____

Description of Information Requested: _Diagnostic and Treatment History_____

_____

Reason for this request: ____Coordination of Services_____

_____

_____

_____ _____
Client Signature Witness

_____ _____
Parent or Legal Guardian Date

This authorization is valid for 90 days and can be revoked in writing at any time.