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 based in 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_____

☐ *I acknowledge that once information is shared with the person or organization listed above, it may not be protected under the same privacy rules that apply in therapy (HIPAA), and I accept this as part of my consent.*

_____ _____

Client Signature Date

_____ _____

Parent or Legal Guardian (if applies) Date

This authorization is valid for the duration of treatment and can be revoked in writing at any time.