

**Sophie Guellati-Salcedo, Ph.D.**

Licensed Psychologist

[sophie.guellati@gmail.com](mailto:sophie.guellati@gmail.com)

Tel. : (305) 799 9970

Fax : (305) 663 1856

1450 Madruga Avenue

Suite 201

Coral Gables, FL 33146

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**Authorization for Release of Information**

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

**Authorization: I hereby authorize**

Name of Professional/Organization: \_\_\_\_\_

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

\_\_\_\_\_

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

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

Name of Professional/Organization: \_\_\_\_\_

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

\_\_\_\_\_

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

**Description of Information Requested:** \_\_\_\_\_

\_\_\_\_\_

**Reason for this request:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

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