AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby give permission to:

New Objectives Psychology, Counseling & Neurofeedback Center
and its associates,
370 CenterPointe Circle, Suite 1160
Altamonte Springs, FL 32701

T: (407) 339-1159 NewObjectivesCenter@gmail.com F: (407) 339-2405

to release to/communicate with: Name: _____

☐ Primary Care Physician ☐ Psychiatrist ☐ Teacher
☐ Attorney ☐ Spouse ☐ Other: _____

_____
Address

_____
City, State, Zip

_____
Phone# Fax#

and for the above named to release and/or communicate with New Objectives Psychology, Counseling & Neurofeedback, Center, Inc. and any of its associates any information regarding my treatment, diagnosis, progress and records of any treatment or examination rendered to me

for the purpose of: Coordination of Care

I understand that my records are protected under the Federal Confidentiality Regulations as well as Florida State Law. My records cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by so informing the above-named parties in writing; however, such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year after I terminate treatment with the above-named parties. I hereby release New Objectives Psychology, Counseling & Neurofeedback Center, Inc. and any of its associates from any and all liability that may arise from the release of information as I have directed.

Client's Name: _____ Date of Birth: _____
(Please Print)

Client's Signature: _____ Date Signed: _____
(If a minor, Parent/Legal Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION"

The federal government mandated that as of April 14, 2003, all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. parts 160 and 164).

This acknowledgement documents that New Objectives Psychology, Counseling and Neurofeedback Center, Inc. (hereafter known as NOPCNC) has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

- How your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice).
- Which uses and disclosures require authorization from you and which don't.
- How you may revoke an authorization you have made.
- Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures.
- A list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes.
- What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make.
- Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

The Privacy Notice is a few pages in length. Generally, this Notice is given on a patients' first visit unless there is good reason to delay. A copy of this Notice is available in my waiting room and will be on my website. I will also give you a copy of this notice. This page documents that I have given you a copy of the Notice.

Date: _____

_____	_____
Print Patient's Name	Signature
_____	_____
Print name of Parent or Legal Guardian, if patient is a Minor, Personal Representative	Signature

Describe your role in regard to the patient and/or the authority by which the person is signing for the Patient:

_____

INNER-OFFICE RELEASE

I hereby authorize and give permission for Sharon R. Thetford, Psy.D. and Karen A. Rifkin, L.M.H.C. to release and/or communicate with each other regarding my treatment, diagnosis and progress and records of any treatment or examination rendered to me to include any Federal and State protected information, under Florida Statute 394.459(9) Psychiatric information, Florida Statute 397.053 and 396.112 Drug and/or Alcohol Abuse information and Florida Statute 381.609(2) Human Immunodeficiency Virus Test results (AIDS and related conditions).

I understand that this authorization will remain in effect for six (6) months or until treatment has been terminated, whichever is later, or until I revoke it in writing. I hereby release New Objectives Psychology, Counseling and Neurofeedback Center, Inc. and any of its associates from any and all liability that may arise from the release of information as I have directed.

Client Name: _____ Date of Birth: _____

Client Signature: _____ Date: _____
(Parent/Legal Guardian)

Witness Signature: _____ Date: _____