NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby give permission to:
New Objectives
Psychology, Counseling & Neurofeedback Center
and its associates at
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: _____

☐PCP ☐Psychiatrist ☐Teacher
☐ Attorney ☐ Spouse ☐ Other _____

_____
Address

_____
City, State, Zip

_____
Phone# Fax#

and for the above named to release to/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 assessment rendered to me

for the purpose of: _____

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.

Patient's Name_____ Date of Birth _____
(Please Print)

Patient's Signature_____ Date Signed_____
(If a minor, Parent/Legal Guardian)

INTER-OFFICE RELEASE

I hereby authorize and give permission for
Sharon R. Thetford, Psy.D. and ***Karen A. Rifkin, LMHC***

to release to and/or communicate with each other information 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.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____
(Parent/Legal Guardian, if patient is a minor)