AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby give permission to:
New Objectives
Psychology, Counseling & Neurofeedback Center
and its associates at
620 Crown Oak Center Dr,
Longwood, FL 32750
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)