COX BEHAVIORAL HEALTH GROUP LLC.

Consent for Release and Receipt of Confidential Information

I, _____, hereby authorize Cox Behavioral Health Group LLC
client or /parent name

to disclose confidential information contained in my client record / my child's client record
and to receive information from the person or organization named here, under the conditions indicated below:

Name and/or Organization authorized to share and receive information: ***(NOTE:** Check **ONLY ONE** box per form.)*			
	DJJ:		SSI/SSDI:
Phone:		*Phone:*	
	DOC:		Other:
Phone:		*Phone:*	
	DCF:		Other:
Phone:		*Phone:*	
	School:		Other:
Phone:		*Phone:*	
Nature / content of information to be disclosed: *(check **ONLY** items that apply)*			
	results of assessments / evaluations		treatment recommendations
	participation / progress in treatment		nature of program discharge
	referrals		attendance of other programs
	other (specify):		
Purpose:			

I understand that my records are protected under the Code of Federal Regulations (42 CFR Part 2), and 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 except to the extent that action has been taken in reliance thereon, and that in any event this consent expires automatically on _____ (no later than twelve months from signing). Consent may be revoked in writing to the Cox Behavioral Group LLC P.O. 13720 Old St. Augustine Road, Ste. 8-221 Jacksonville, FL 32258 or in person at the office where services are offered.

_____ _____
client signature date

_____ _____
parent / guardian signature (if applicable) date

_____ _____
witness signature date

revised 11/26/2013