



**Anxiety and OCD
Treatment Center
of Ann Arbor**
Providing evidence-based treatment across the lifespan

CONSENT FOR RELEASE OR EXCHANGE OF INFORMATION

I, _____, authorize the disclosure and exchange of my/my child's academic, medical, mental health or legal information between the following individual or group and the Anxiety and OCD Treatment Centers of Michigan, its affiliates and Dr Jodene G Fine.

This agreement is regarding _____
Client's Name and Date of Birth

Enter details for any individual or group with whom information about your care can be exchanged.

_____ Name	_____ Relationship to client	_____ Email Address
_____ Address	_____ City/State	_____ Zip Code
_____ Organization, if applicable	_____ Phone Number	_____ Fax Number

Specific information to be released or discussed:

- ☐ billing ☐ appointments ☐ recent visit note ☐ Full medication list
- ☐ Entire academic record ☐ Entire medical record ☐ Entire psychiatric/mental health record
- ☐ History and physical development ☐ Psychological testing and/or psychological treatment summary
- ☐ Neuropsychological testing ☐ Medical summaries ☐ MRI/CT/EEG reports ☐ Lab reports
- ☐ Other _____
- ☐ Verbal Communication regarding any of the above ☐ All of the above

Any exclusions: None

For the purpose of Coordination of Care and/or Neuropsychological Services.

Expiration (date/condition/event): one year from date signed or end of treatment

I understand that I have the right to revoke this authorization at any time by sending written notification to the Anxiety and OCD Treatment Center of Ann Arbor main office at the address listed below. I understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

I am signing this release voluntarily and not as a condition of my treatment with the Anxiety and OCD Treatment Centers of Michigan, its affiliates or any other clinic/provider.

Unless specifically excluded, this authorization may include any information contained in my/our psychological or mental health records, including any alcohol and drug abuse treatment, any information related to HIV infection, Acquired Immunodeficiency (AIDS) and AIDS Related Complex (ARC), and psychiatric, psychological or social work services records,

including communications made by me/us to you, under the conditions described above. This release does not consent to share "psychotherapy notes."

Unless I have specifically requested in writing that the disclosure be made in a certain format, I understand that the Anxiety and OCD Treatment Centers of Michigan, their affiliates and Dr Fine reserve the right to disclose information as permitted by this authorization in a manner they deem appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Signature of client or parent/guardian

Date

Printed Name

Relationship to client