Anxiety and OCD Treatment Center of Ann Arbor

Providing evidence-based treatment across the lifespan

PCP ROI

I, _____ ☐*DO* ☐*DO NOT* authorize the Anxiety and OCD Treatment
(CLIENT NAME) *(CHECK ONE)*
Center of Ann Arbor to release information contained in my client record to my PCP (Primary Care Physician) below and for my PCP to release information to the Anxiety and OCD Treatment Center of Ann Arbor. If consent is provided, information will be released as follows:

1. Type of Information to be disclosed: **assessment &/or treatment information**
2. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance upon this release. This release will terminate on:

   A. Date: _____

   B. Event: 6 months after date of my discharge from the Anxiety and OCD Treatment Center of Ann Arbor

   C. Condition: _____

_____ _____
Witness Client Signature (or parent/guardian)

_____ _____
Date Witnessed Date Signed

*I understand that my consent to release information will include sending of the information below to my PCP, as well as treatment updates, discharge information (e.g. a summary of my treatment) and any other information deemed necessary to coordinate my treatment at the Anxiety and OCD Treatment Center of Ann Arbor. I understand that this release is reciprocal, meaning that it also permits my PCP to send/communicate information to the Anxiety and OCD Treatment Center of Ann Arbor.

Initial Patient Care Communication to Primary Care Physician

Name of Patient: _____(DOB)_____

Dr: _____ Phone: _____

Address: _____ Fax: _____

Anxiety and OCD Treatment Center of Ann Arbor use only

Date of Assessment _____/_____/_____ DSM-5 Diagnosis: _____

☐Patient has been referred to you for initial &/or continued treatment with psychiatric medi c ation(s)
☐Patient has been referred to a community provider for initial &/or continued treatment with psychiatric medi c ation(s)
☐Patient has dec lined referral for psychiatric medi c ation treatment
☐Patient will attempt behavioral health interventions before a psychiatric medic ation trial
☐Patient will receive behavioral health treatment only

Beha vioral Health Treatment Plan Information

Modality ☐Indiv idual ☐Group **Type of Therapy** ☐Exposure Therapy ☐Habit Reversal ☐Cognitive Therapy ☐_____

Frequency ☐Weekly ☐Biweekly ☐_____ Estimated Treatment Completion Date ____/_____/____

Please contact me with any questions or comments ☐Mailed ☐Faxed on _____
(DATE)

_____ _____
Behavioral Health Provider Name & Credentials Phone Behavioral Health Provider's Signature

Under federal and state law, re-disclosure of this information may require the authorization of the patient to whom the information pertains, or his/her personal representative (e.g., legal guardian, parent of a minor child). Please consider the need for written authorization before you re-disclose any of this information. 6.2016