Anxiety and OCD Treatment Center of Ann Arbor

Providing evidence-based treatment across the lifespan

CONSENT FOR RELEASE OR EXCHANGE OF INFORMATION

I/We, _____,
authorize the Anxiety and OCD Treatment Center of Ann Arbor to □ disclose information to or □ exchange information with

_____
Name, Organization/Title

_____
Contact Information

Regarding □ myself or □ my/our minor child _____
Client's name and Date of Birth

Type of information to be disclosed or exchanged: _____Mental Health_____
Any exclusions: _____None_____
For the purpose of _____Continuation of Care_____.
This authorization expires (date/condition/event): one year from date signed or end of treatment

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

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.

Unless I/we have specifically requested in writing that the disclosure be made in a certain format, I/we understand that the Anxiety and OCD Treatment Center of Ann Arbor reserves 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(s) or parent/guardian date

_____
Signature of witness date