



**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
 exchange information with and/or request records from

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.

I am signing this release voluntarily and not as a condition of my treatment with the Anxiety and OCD Treatment Center of Ann Arbor 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.

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 Si

Signature of witness date Si