International OCD Foundation (IOCDF)

Behavior Therapy Training Institute — Patient Release Form

1.) I, _____, do hereby give my consent to the performance of treatment by means of cognitive/behavioral therapy (the Treatment) for relief of obsessive-compulsive disorder (OCD).

2.) I understand that my licensed mental-health practitioner, _____, (the Practitioner) will participate in a clinical teaching program known as the IOCDF Behavior Therapy Training Institute (the Institute) and that the teaching faculty of the Institute will consult my Practitioner concerning my Treatment.

3.) I understand that as part of the Treatment I will gradually be exposed to situations that trigger my obsessive thought, obsessive images, or compulsive actions (the Actions) and that I will be taught ways to manage my anxiety or discomfort and how to resist engaging in compulsions. I have made my decision voluntarily and freely.

4.) I fully understand that the Treatment to be performed has been documented in controlled outcome studies to be effective with a majority of patients with OCD; but, the Treatment outcome for any single patient cannot be predicted.

5.) I appreciate that there are certain risks associated with the Treatment including, but not limited to, being subjected to anxiety from exposure therapy, the fact that not all patients in behavior therapy respond to the Treatment, and the fact that a reduction in OCD symptoms may change the existing family dynamics, and I freely assume these risks. I also understand there are certain benefits associated with this treatment. However, I understand there is no certainty that I will achieve any benefit and no guarantee has been made to me regarding the outcome of Treatment.

6.) The "reasonable alternatives" to the Treatment have been explained to me including the use of medications to treat OCD. I am also aware that insight-oriented psychotherapy and supportive psychotherapy may be helpful to some individuals with OCD.

7.) I agree to hold the Practitioner and the faculty, staff, participants, and sponsors of the Institute free and harmless of any claims, demands or suits for damages from injury or complications whatever, save negligence, that may result from such Treatment.

8.) I authorize the Practitioner to disclose complete information in confidence to the Institute concerning his or her medical findings and treatment of me from on or about _____ until the date of the conclusion of such Treatment. I release the Practitioner and the faculty, staff, and participants of the Institute from all legal responsibilities that may arise from this authorization.

9.) Any questions I have had regarding the Treatment have been answered to my satisfaction.

10.) I, the undersigned, having been fully informed by the Practitioner of the above, nevertheless consent to such Treatment and hereby freely and voluntarily give my signed authorization for this Treatment.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____