Shelley Mackaman, Ph. D.
Redmond Medical Center
8301 161st. Ave. NE, Suite 300 Redmond, Washington 98052
Phone: 425-885-3330, Fax: 425-702-2474

Client Consent and Disclosure of Records and Information

I, _____ Date of Birth: _____
Client Name
Parent or Guardian's name is signing for client _____
Hereby authorize Dr. Shelley Mackaman, at the above address:

Check one only: Name, Address and/or Telephone of Person, Facility or Program

_____ to disclose to:_____

_____ to obtain from: _____

_____ to exchange with:_____

The following specific information and records requested:

Please check each to be released:

_____ Verbal and/or telephone contact/exchange
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Medications, Medical Reports, and Information
_____ Treatment Summary
_____ School Reports
_____ Progress Notes
_____ Intake Summary

Other:_____

Purpose and need for disclosure:
_____ To facilitate and coordinate treatment planning
_____ Continuity of Care
_____ Other

Restrictions:_____

My consent for disclosure shall automatically expire at 90 days:_____
Expiration Date

This authorization may be revoked by me in writing at any time.
My signature below allows information concerning myself, which may include protected medical information related to drug, alcohol, HIV/AIDS, and sexually transmitted diseases to be released.

_____ I give consent for release of this information
_____ I do NOT give consent for release of this information.

Date:_____ Client's Signature: _____

Witness:_____ Guardian's Signature:_____