



CAROLINA INTEGRATIVE PSYCHOTHERAPY, INC.

Consent for Release of Confidential Information

I hereby authorize and request John Mader, MA, LMFT to

Release To Obtain From

_____ Therapist Name and Location

...pertinent confidential information regarding _____
Client Name and Date of Birth

All records and communications between client and psychotherapist are both privileged and confidential. Such records may only be released upon written authorization by the patient or legal guardian or as otherwise provided by law.

Information to be Released:

Consultation only

Purpose of Disclosure:

Assessment and Treatment

I release the parties named above from liability arising from disclosure pursuant to this authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I certify that I have the required legal standing for myself or, in the case of a minor child, have legal custody and/or other required legal right to authorize the release of confidential information. A copy of this authorization is to be considered as valid as the original.

Signature Date

(If client is a minor, please specify relationship to person signing)

John Mader, MA, LMFT
Licensed Marriage and Family Therapist #470 NPI#1639158892
Carolina Integrative Psychotherapy, Inc. EIN#33-1136402