Stoner Counseling Services, LLC
2101 4th AVE E STE 200
Olympia, WA 98506
360-786-9499

Authorization for Release of Confidential Information

I, (*client)* _____

Client date of birth _____

hereby authorize (*William) Bill Stoner, MA, LMHC, Stoner Counseling Services, LLC*, **and** *staff with Phoenix Offices, LLC* to release and receive (exchange) any information listed below to or with:

This consent of release of information is active for a maximum of six (6) months after our most recent counseling session. This authorization may be revoked at any time via written and signed notice from the client to *Stoner Counseling Services, LLC (e-mail and similar are not acceptable for this use)*. The information exchanged will be disclosed from records of which confidentiality is protected by federal and or state law. *Stoner Counseling Services, LLC* will not release information as requested if there is an outstanding balance on the account. Other fees and limitations may apply as outlined in the Professional Disclosure.

The information on this release was explained to me and this consent is given on my own free will.

Initial on each line (below) that applies to this release.

	Identifying information
	Appointment dates/times
	Treatment plan/summary
	Progress notes/dates of service
	Payment information

	Diagnosis; mental
	Diagnosis; medical
	Diagnosis; HIV/AIDS
	Legal status/issues
	Testing Documentation

Client Signature

Bill Stoner, MA, LMHC

Address, City, State, ZIP

Date signed