Stoner
COUNSELING SERVICES LLC

Authorization for Release of Confidential Information (ROI)

I, *(print client legal name)*	
Client date of birth	

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

Name of Person (print name)	**Relationship to Client**

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 notice from the client to *Stoner Counseling Services, LLC* (e-mail and similar are 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 form 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		Diagnosis; mental
	Appointment dates/times		Diagnosis; medical
	Treatment plan/summary		Diagnosis; HIV/AIDS
	Progress notes/dates of service		Legal status/issues
	Payment information		Psychological testing results

Client Signature (*legal name*)		**Bill Stoner, MA, LMHC**
Date signed		