

# Gail A. Phillips, LCSW

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(404) 982-9010

## Authorization for Release of Information

For continuity of care, I \_\_\_\_\_, authorize  
(print full name)

Gail Phillips, LCSW, to communicate with the following person(s):

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

I understand that this authorization will remain effective for one year and that I may revoke it at any time.

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness Signature (Gail Phillips, LCSW)

\_\_\_\_\_

Date