Gail A. Phillips, LCSW

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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