Tiffany Phillips, M.A., LMFT TN #669
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Authorization for Release of Confidential Information

_____ _____
Name of Client Date of Birth

_____ _____
Address City, State, Zip

I, _____,

hereby authorize Tiffany Phillips, M.A., LMFT to exchange information with

_____
(Organization/Person) (Phone Number/Fax Number)

_____
(Address) (City, State, Zip)

Purpose::

_____Emergency Contact _____Financial Payments _____Treatment Coordination

_____Other: _____

I understand that I may withdraw this authorization at any time by submitting a written notice and that this authorization shall expire, without my express revocation, exactly one year from the date provided below.

My treatment will not be affected if I refuse to sign this form.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian (if applicable) Date