Release of Information
Connect Therapies LLC

Name _____ DOB _____ Today's Date _____

Parent or Legal Guardian Name (if minor)_____

Request to Obtain information for the purpose of coordinating care:

Sally Blevins MA LPC
3410 Williams Drive Suite 146
Montrose, CO 81401
970-286-0054
sally@connecttherapiesllc.com

Authorization to Exchange Client Information with:

Entity _____

Address _____

Phone _____ Fax _____

Email_____

Specific Information to be Released:

____ Diagnosis/ Symptoms

____ Client History/ Current Issues
____ Treatment Summary/ Recommendations
____ Psychological Testing/ Evaluation

____ Medical Information/ Medications Prescribed

Authorization:

I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time by written notice to Sally Blevins MA, LPC except to the extent that the action has already been taken to comply with it. Without my written revocation this authorization will expire one year from the date signed. I hereby release the above parties from liability that may result from furnishing this information. A copy of this authorization may be used with the same effectiveness as the original.

Signature _____

Printed Name _____

Today's Date _____