Revocation of Authorization for Release of Health Information
Connect Therapies PLLC
1124 S 11th Street Montrose, CO 81401

Use this form to revoke or take away permission to get or share health information.

Client Information
Full Name _____

Address _____

City _____ State _____ ZIP _____

Date of Birth _____

Who is being revoked from getting and sharing my information?

I revoke permission for Connect Therapies PLLC and the following therapist _Sally Blevins MA LPC_LCPC to obtain from or share my health information with:

Full name of person(s) or name of organization(s)

_____

Signature
By signing below, I understand and agree that:
This revocation is voluntary.
Cancellation of my permission is effective on the date my request is processed.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian if client is under age sixteen. Date