

**Release of Information  
Connect Therapies PLLC  
5655 S Yosemite Street Suite 350  
Greenwood Village, CO 80111  
<https://www.connecttherapiesllc.com>**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

**Request to Obtain information for the purpose of coordinating care:**

Sally Blevins MA LPC LCPC MHC  
Mailing address:  
1124 S 11th Street  
Montrose, Colorado 81401  
970-286-0054  
[sally@connecttherapiesllc.com](mailto:sally@connecttherapiesllc.com)

**Authorization to Exchange Client Information with:**

Entity/Name \_\_\_\_\_

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 LCPC 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 \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

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