

Revocation of Authorization for Release of Health Information
Connect Therapies PLLC
56555 S. Yosemite Street Suite 350
Greenwood Village, CO 80111
970-286-0054

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 MHC 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