# JOYCE LOPEZ & ASSOCIATES, LLC

*"In your moments of challenge, you will need a vision of how...to go above and beyond."*

## AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION

Client's Name:_____ Date of Birth:_____

Social Security Number:_____ To/From:_____

Name of Provider/Facility:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

You are hereby authorized to release to and/or receive from:

**JOYCE LOPEZ & ASSOCIATES, LLC**

**60 EVERGREEN PLACE, SUITE 408**

**EAST ORANGE, NJ 07017**

**PHONE: (973) 678-6585 FAX (973) 673-8888**

The following protected health information for the purpose of:

- Progress Reports
- Medical Records
- Intake and Discharge Summaries
- Telephone Consultations
- Drug & Alcohol Testing Report
- Other (Specify)_____

I have been informed of the type of information to be released and the benefits and disadvantages of the release. I understand that treatment service are not contingent upon my decision to authorized or unauthorized release of information. I understand that I may revoke this authorization at any time by submitting a written and signed order to revoke.

This authorization cannot exceed one (1) year and will expire automatically from signed order to revoke.

Client's Signature:_____ Date:_____

Witness:_____ Date:_____

***JL/cb***