ST. FRANCIS
MEDICAL CENTER
601 Hamilton Avenue
Trenton, NJ 08629
(609) 599-5000
Fax (609) 599-5692

# Authorization for the Release of Records and Information

Name: _____

D.O.B. _____

Address:

_____

_____

_____

Social Security #: _____

I, _____, hereby authorize you to release to R1/ Trinity Health System, any information related to my age, residence, citizenship, employment, income, assets, and or bank account statements. It is understood that the information obtained will be used only for purposes directly related to eligibility for Social Security Programs, Medicaid, and the New Jersey Hospital Care Payment Assistance Program.

**This release is made voluntarily and with full understanding.**

Signature: _____ Date: _____



Thank you.