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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: _____

The information contained in this form is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the recipient, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address via the U.S. Postal Service.

Thank you.