Adreima
400 Broadacres Dr.
Bloomfield, NJ 07003
(973)614-9100
(973)614-0101 (Fax)

Saint Michael's Medical Center

Date: _____

AUTHORIZATION FOR THE RELEASE OF RECORDS AND INFORMATION

Name: _____
Address: _____
_____
_____

Social Security #: _____ **Birth Date:** _____

I, _____, hereby authorize you to release to Adreima/ Catholic Health East, 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 the purposes directly related to eligibility for Social Security programs, Medicaid, and the New Jersey State Hospital Care Assistance Program.

This release is made voluntarily and with my full understanding.

Signature: X _____ **Date:** _____