

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



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: _____

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.