Cooper
University Health Care

AUTHORIZATION FOR THE RELEASE OF RECORDS AND INFORMATION

Name: _____**D.O.B**.: _____

Address: _____

_____

Social Security: _____

I_____, hereby authorize you to release to Adreima./Cooper University Health Care , 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 State Hospital Care Assistance Program.

This release is made voluntarily and with my 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.