RELEASE OF INFORMATION

Date:_____

I _____ hereby authorize you to release Employment, Insurance,
Print Name
Income, Bank Account balances, etc., to Lourdes Medical Center of Burlington County. This information will help me to apply for financial assistance with my hospital bills.

I understand that Lourdes Medical Center of Burlington County Financial Counselors are required to keep all information confidential and that further disclosure of information is prohibited without my express written consent.

I am aware that this authorization will expire one year from my dated signature.

_____ _____

Patient Signature Date