LIBERTY HOUSE FOUNDATION, INC.

54 BAY STREET
GLENS FALLS, NY 12801

CONSENT FOR RELEASE OF INFORMATION

Extent or Nature of Information to be Disclosed:

_____ Presence in treatment
_____ Clinical Summary
_____ Discharge Summary
_____ Psychiatric Assessment
_____ Psychological Assessment
_____ School Records
_____ Other

Purpose or Need of Information:

Name & Address of Person or Organization Disclosing Information:

Name & Address of Person or Organization to Which Disclosure is to be Made:

Liberty House Foundation, Inc.
54 Bay Street
Glens Falls, NY 12801

I hereby authorize the release of the above information from my medical record. I understand that the information to be released from my medical record is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time before it is released.

Authorization Expires: _____

Signature of Patient: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Print or Type Name: _____ **Title:** _____

Revised: 06/02/16