Authorization for Release of Personal Information

PRINT NAME	DATE OF BIRTH
STREET ADDRESS, CITY, STATE, and ZIP	
PHONE NUMBERS (CELL AND HOME)	

_______I understand that information about my situation and my interactions with Kearsarge Neighborhood Partners ("KNP") will be documented on a database and accessible to a limited number of KNP volunteers on a "need to know" basis.

In addition, I hereby authorize Kearsarge Neighborhood Partners ("KNP"), or any employee or representative of Kearsarge Neighborhood Partners, PO Box 1442, New London, NH 03257 to share and discuss information with Authorized Representatives of the following Service Organizations who may also be involved in my care. Said information may be personal, financial, or otherwise deemed confidential. **(Please select approved Service Organizations)**.

____ **All Organizations Listed**
____ (CAP) Community Action Program
____ COA Chapin Center
____ Food Pantries
____ KREM
____ Loaves and Fishes
____ New London Hospital
____ Newport Health Center
____ School Officials
____ ServiceLink Concord
____ Town Welfare
____ VNA – Visiting Nurses Association
____ Warner Connects

Please Add Any Unlisted Service Organizations

____
____
____
____
____

Note:

- You have the right to withdraw your permission at any time. To withdraw your permission simply notify your Kearsarge Neighborhood Partners Representative.
- This release shall expire one (1) year from the date of the signature appearing below unless permission is taken back sooner.
- A photocopy, fax or electronic copy of this release shall be as valid as the original.

Signature of Person or Person's Authorized Representative: ____________________________________

Title: ____

Date: ____

Witness:____