



Cornell University
Faculty and Staff
Assistance Program

FSAP
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Authorization for Release of Confidential Information

Client name \_\_\_\_\_ Date of birth \_\_\_\_\_ mm/dd/yyyy

I hereby authorize the Faculty and Staff Assistance Program

[ ] To provide information to:
Name/Organization \_\_\_\_\_
Mailing address \_\_\_\_\_
Phone \_\_\_\_\_ Fax \_\_\_\_\_

[ ] To receive information from:
[ ] Same as above
Name/Organization \_\_\_\_\_
Mailing address \_\_\_\_\_
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Purpose of confidential information to be provided/received

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nature and/or extent of information to be provided/received

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Duration of this authorization

- [ ] I authorize the ONE-TIME RELEASE of the above confidential information. I understand I may revoke this authorization in writing at any time, except to the extent that FSAP has already relied on this authorization. I may revoke it by providing written notice to FSAP. Otherwise, my consent to release will expire in 30 days.
[ ] I authorize the PERIODIC RELEASE of the above confidential information, as often as necessary to plan for and provide care. I understand I may revoke this authorization in writing at any time, except to the extent that FSAP has already relied on this authorization. I may revoke it by providing written notice to FSAP. My consent to release will expire when I am no longer receiving services from FSAP, or one year from this date.

Signature \_\_\_\_\_

Today's date (mm/dd/yyyy) \_\_\_\_\_

Expiration date (mm/dd/yyyy) \_\_\_\_\_