Cornell University
Faculty and Staff
Assistance Program

FSAP
312 College Ave. Suite A
Ithaca, NY 14850
t. 607.255.2673
f. 607 255.6681
web: fsap.cornell.edu

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) _____