THE CITY UNIVERSITY OF NEW YORK
College of Staten Island

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name: _____EMPLID:_____

Internal Release
I give the Center for Student Accessibility at the College of Staten Island permission to release and receive information from all of the college Departments, Programs and Services, including all Faculty and Staff on campus.

Comments:

_____

_____

External Release
I give permission for CSA to release and receive information from:

_____
Name of Agency or Person(s)

_____
Street Address City State Zip Code

Comments:

_____

_____

I understand that I have the right to withdraw this authorization at any time and that the request to withdraw this information must be in writing. I also understand that this authorization is valid throughout my enrollment at The College of Staten Island.

Student Signature: _____ **Date:** _____

CSA Staff Signature: _____ **Date:** _____

Submit