Wesleyan University

Counseling and Psychological Services

AD/HD Exchange of Information Form

Student Name: ___________________________ Wes ID: ___________________

I ________________________________, hereby authorize _________________ to exchange information with Wesleyan University, Counseling and Psychological Services (CAPS). The following documentation is required for successful continuity of care.

Required Documentation:

- Neuropsychological testing report, which contains a finding of ADD/ADHD, to be examined by a CAPS psychologist
- Documentation of medications prescribed with dose and frequency, including last date prescribed
- Other ____

This release is not to be construed as a release of any information other than that specified above or for any other purpose than that specified above. I may terminate this authorization in writing at any time.

Name: _____________________________________ DOB: ___________________

Signature: _________________________________ Date: ___________________

Mail information to:

Wesleyan University
Counseling and Psychological Services
327 High Street
Middletown, CT 06459

Fax information to: (860)685-3961