Wesleyan University

CAPS Exchange of Information Form

Medication Refill/Continuation

To be completed by student:

I __________________________ hereby authorize ______________________ to exchange information
(Student Name) (Name of Provider)
with Wesleyan University, Counseling and Psychological Services (CAPS) regarding my current medical condition for the purpose of continuation of care while at the college. I understand that records relating to patient identity, diagnosis, prognosis or treatment are confidential under HIPAA. I understand that I have the right to revoke this authorization, and understand that CAPS will provide me with the means to revoke that permission.

Print name: ____ DOB: _______________________

Signature: ____ Date: _______________________

To be filled out by health care provider/prescriber:

Diagnosis:____
____

Medication(s): ____
____
____

Recommended Follow-up Labs: ____

***Attach recent laboratory tests (if applicable) ***

Provider Signature: ____

Printed Name: ____

Address: ____

Telephone #: __________________________________ Fax #: _________________________________

I hereby terminate the release of information stated above.

Name: ___________________________ Signature: ________________________________ Date: _________

Please mail or fax the completed form to:

Wesleyan University, CAPS
327 High Street
Middletown, CT 06459
Phone: (860) 685-2910 Fax: (860)685-3961 Email: kscheinberg@wesleyan.edu