Wesleyan University

Counseling and Psychological Services

Psychiatric Medication Exchange of Information

*** Please give this form to your provider's office to include when sending your records to Wesleyan CAPS.*

Student Name: _____ **Date of Birth:** _____

I hereby authorize _____ to communicate with Wesleyan University Counseling and Psychological Services for the purposes of coordinating psychiatric. This authorization will allow both parties to send and receive information to the extent necessary to ensure continuity of care, including information about diagnosis, psychiatric evaluation, office visit notes, medication history, medical and surgical history, relevant family and social history, and lab and testing results. I understand this is protected information under HIPAA. Additionally, I authorize my providers to discuss substance use history as relevant to my treatment, which is protected under 42 CFR Part 2. Information that I **do not** want exchanged is noted below:

_____

I understand I may revoke this authorization at any time by providing a written request to CAPS.

Signature: _____ **Date:** _____

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To be filled out by healthcare provider:

Initial visit date and date last seen: _____

Diagnosis: _____

Current medications, including dose and frequency: _____

Signature of provider: _____ **Date:** _____

PLEASE ATTACH INITIAL EVALUATION, OFFICE VISIT NOTES, LAB/TESTING RESULTS, AND MEDICATION HISTORY AS AVAILABLE.

Send information to:

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

Fax: (860) 685-3961
E-Mail: counseling@wesleyan.edu