CONNECTICUT COLLEGE

Exchange of Information Form
Medication Refills

To be completed by student:

I _____hereby authorize _____to
(Student Name) (Name of Provider)
exchange information with Connecticut College, Student Health Services regarding my current medical condition for the purpose of continuation of care while at the college. I understand that Personal Health Information (PHI) once disclosed to others may be re-disclosed. I understand that records relating to patient identity, diagnosis, prognosis or treatment are confidential under HIPAA. I understand I have the right to revoke this authorization, and understand that Student Health Services will provide me with the means to revoke that permission.

Print Name: _____Date of Birth:_____

Signature: _____ Date:_____

To Be filled out by Healthcare Provider/prescriber:

Diagnosis: _____
_____

Medication(s): _____
_____
_____
(Including dosage and frequency of medication)

Recommended Follow-up Labs: _____
Attach recent laboratory test (if applicable)

Provider Signature: _____

Printed Name: _____

Address:_____

Telephone#:_____ Fax#:_____

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I hereby terminate the release of information stated above.

Name:_____Signature:_____ Date: _____

Please mail or fax the completed form to: Connecticut College, Student Health

270 Mohegan Avenue, New London, CT 06320
Phone: 860 439-2275 FAX 860 439-5430 E-Mail shs@conncoll.edu