Connecticut College
Student Health Services

AD/HD Exchange of Information Form

I_____ Class of_____, hereby
Student Name
authorize _____ to exchange
Name of Outside Provider
information with **Connecticut College, Student Health Services**.

Required Documentation:

- Educational/psychological testing and those results that establish the diagnosis of AD/HD (aka ADD,ADHD) or Provider Clinic Notes as appropriate
- Medication with dose and pattern of administration
- Other _____

For the Purpose of: Continuity of Care

_____

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:_____ Date of Birth_____
Please Print

Signed: _____ Date: _____

Mail information to: CC Student Health Services
270 Mohegan Avenue
New London, CT 06320

Fax information to: (860) 439-5430