CONNECTICUT COLLEGE

STUDENT HEALTH SERVICES

MEDICAL LEAVE
EXCHANGE OF INFORMATION FORM

I, _____, class of, _____, hereby authorize

_____ to exchange information about my current condition,
(Name of Provider)

visit date of _____, with Student Health Services.

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 and I understand that I may terminate this authorization, in writing, at any time.

Name: _____ Date of Birth: _____

Signed: _____ Date: _____

I hereby terminate the release of information as stated above.

Signed: _____ Date: _____

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