Trinity College Health Center, with Care Provided by
Hartford HealthCare, Campus Care
300 Summit Street
Hartford, CT 06106-3100
p) 860.297.2018
f) 860.297.2020
e) healthcenter@trincoll.edu

Dear Student,

If you are regularly prescribed medications(s) by your doctor at home, and are needing to transfer the refills of these medication(s) while you are a student at Trinity College, **please initial below and have your prescribing doctor complete the attached forms in their entirety for each prescription that will need to be refilled during the school year.** Upon receipt of these forms, a medical provider at Trinity College Health Center (TCHC) will review the information and contact you with any questions prior to you scheduling an appointment for medication refills. Please note that your doctor at home will resume prescribing your medications when you are home during college breaks, as they deem medically appropriate.

We require that the attached form be completed by your current prescriber and include an official office stamp. The form needs to be received by the TCHC office ***prior*** to the scheduling of this refill-related appointment. Please either:

- Upload to the Health Center Portal,
- Mail to 300 Summit Street, Attn: Health Center, Hartford, CT, 06106,
- Fax to (860) 297-2020, or
- Hand-deliver in advance of scheduling your first visit at TCHC for prescription monitoring.
- If you prefer to email your documents, please contact the Health Center for a *secure* email to reply to with these documents attached. It is not advised to email personal health information through non-secured means.

If there any questions, please call the Health Center at 860-297-2018, or email us at healthcenter@trincoll.edu.

Sincerely,
The Health Center Staff

Student or Legal Guardian, to be considered for this prescription transfer, please initial that you agree:

To only receive this prescription from TCHC for the time that you are residing at Trinity College.	
That you are responsible for following up with your PCP for prescriptions when home for breaks.	
That you are stable on your medication, with no recent changes (within the last 6 months).	
To come to TCHC for monthly appointments for each prescription.	
To keep your medication in a safe and secure location.	
That if your medication is lost or stolen, you will not receive an early refill.	
That you will not share this medication with others.	
To return to your home prescriber or be referred off-campus for any possible dose titration, at least until you are 6 months stable on your dosage.	

Please initial

Student or Legal Guardian Signature	Print Name	Phone Number	Date

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Name of Student:	
DOB:	Student ID #:
Current Medication List:	Allergies:
Name of Medication to Transfer:	
Indication / Diagnosis:	
When was medication started:	
Current Dosage:	
How long on current dosage:	
Last refilled:	
Any requirements for monitoring / Frequency:	
Any other meds tried in past for same condition and reasons for discontinuation:	
Next scheduled appointment (if applicable):	

I agree to discontinue prescribing for this student the above named medication while this student is residing at Trinity College.	
I understand that, when my patient is home during school-breaks, I will resume prescribing the above named medication as I deem medically appropriate.	
I understand that TCHC medical providers will not be prescribing the above named medication when this student is home for college breaks.	

Physician initial

Physician Name (print):		
Address: ** OFFICE STAMP REQUIRED		
Phone:		
Fax:		
Provider Signature:		Date:

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I, _____ (DOB _____/_____/_____) authorize

To: ☐ Trinity College Health Center

☐ From:_____
Address:_____
Phone:_____
Fax:_____
Email:_____

From: ☐ Trinity College Health Center

☐To: _____
Address:_____
Phone:_____
Fax:_____
Email*:_____

**Emails generated from the Health Center will be secure emails via Hartford Healthcare and all replies to the secure email will remain secure.*

I request that the information to be used or disclosed consist of the following (*if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes):*

CHECK ALL THAT APPLY:

☐ Complete Medical Record ☐ Immunizations X Other (Specify):ongoing, as needed communication

I also specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcoholism or drug abuse) and/or mental health may be used by or disclosed to the above referenced recipients.
It is my understanding that the information to be used or disclosed will be used for the following purposes

CHECK ALL THAT APPLY:

☐ At the request of the individual ☐ Additional Medical Care ☐ Legal Investigation or Action
☐ Insurance Eligibility/Benefits ☐ Change of Provider ☐ Other (Specify): _____

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I may be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that Student Health Services may not condition my treatment, payment, or enrollment/eligibility on my decision to sign this form. I understand that I may revoke this Authorization by notifying Student Health Services in writing of my revocation. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid for one year from date signed unless otherwise specified. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes

_____ _____
Signature—Patient or Legal Guardian **Print Name**

_____ _____ _____
Student ID# **Date** **Contact Phone Number**

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