For HSD Only

Date records sent_____
ID Info taken _____
Paid by _____
Initials _____

The Moody Bible Institute of Chicago
Health Service Department

820 N. LaSalle Blvd.
Chicago, IL 60610
312-329-4417 (Office)
312-329-4419 (Fax)

Date: _____

Release to: _____

_____

_____

Phone: _____

Fax: _____

Re: Authorization Form to Release Patient-Related Information

Please fill out the enclosed form. Sign and return to the Health Service Department at the above address.

Please check records needed:

- **[ ] Immunization Records**
- **[ ] Physical Exam**
- **[ ] Laboratory Test Results**
- **[ ] Medical imaging test reports (i.e. x-rays, CAT scan, MRI, Ultrasound, etc.)**
- **[ ] Other** _____

Mail to:

_____
_____
_____

Authorization for Disclosure of Confidential Health Care Information

Patient Name: _____ Maiden or Previous Name(s) _____
Social Security No.: _____ Birthdate: _____
Student ID#_____ Last year of attendance at MBI:_____
Email Address:_____ Phone:_____
Address:_____

I. Authorization for Release of Information

I hereby authorize records FROM:
Name_____
Address_____
Phone #_____
To be released TO:
Name_____
Address_____
Phone #_____
For the purpose of:
[ ] Transfer of Care [ ] Self/Personal Copy [ ] Insurance [ ] School admission requirement
[ ] Volunteer Work [ ] Other (please specify)_____

Approximate date(s) of treatment:_____

Specific Records to be Disclosed: [ ] Immunization Records **[ ]** Physical Exam
[ ] Laboratory Test Results **[ ]** Medical imaging test reports (i.e. x-rays, CT scan, MRI, Ultrasound)
[ ] Other (please specify)_____

II. Specific Authorization for Release of Protected Information

By checking the box or boxes below, I am authorizing the release of the following information:
[ ] acquired immunodeficiency syndrome (AIDS) or the human immunodeficiency virus (HIV)
[ ] substance abuse (drug(s) or alcohol)
[ ] mental health, behavior, or psychological/psychiatric care or conditions

III. I UNDERSTAND THE FOLLOWING PROVISIONS:

- I understand that I have the right to inspect the disclosed information at any time.
- I have the right to revoke this consent at any time
- Revoking this consent shall have not effect on disclosures made before the revocation of consent
- Any revocation of consent must be submitted in writing to _____ and signed by the person who gave the consent.
- The confidential information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by law.**
- This authorization expires 365 days after it is signed or upon the following specific date, event or condition: _____

_____ _____
Patient's Signature Date

_____
Parent or Guardian signature (if patient is under 18 years old)

_____ _____
Signature of Witness Date

**NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: No person or agency to which this information is disclosed may re-disclose such information unless the person who consented to this disclosure specifically consents to such re-disclosure