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:

________________________________
________________________________
________________________________

Release coversheet
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) Date

__________________________________________________
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

Authorization to release medical info from MBI