MOODY BIBLE INSTITUTE
Student Resource Center
820 N. LaSalle
Chicago, Il 60610-3284
Phone: (312) 329-8177 Fax: (312) 329-4197

AUTHORIZATION FOR RELEASE OF INFORMATION

I (print student name), _____ Social Security #:_____

Address: _____

City, State, Zip Code: _____

Do, hereby authorize **(Name/contact information of the certified diagnostician or doctor)*:***

Name of Individual or institution: _____

Address: _____

City, State, Zip Code: _____

To release the following information to:

MOODY BIBLE INSTITUTE
Student Resource Center
820 N. LaSalle
Chicago, Il 60610-3284
Attention: Gayla Gates, Assistant Dean
Phone: (312) 329-2177 Fax: (312) 329-4197

The following information (please check all that apply):

_____ Medical Reports _____ Medical History _____ Social History

_____ Teacher Progress Reports _____ School Transcripts _____ I.E.P.'s/Transition Plan

_____ Psychological Evaluation_____ Other: _____

I understand that I have the right to inspect and to copy any or all of the above information, which is to be used to determine appropriate educational and/or supportive services.

This authorization is limited to that information specified above. I understand that I have the right to revoke this authorization at any time by submitting a written request and that my refusal to consent to the release of these records will prevent disclosure to the individual or institution named above. I also understand that certain refusal for disclosure may result in lack of accommodations due to documentation needs.

Signature: _____ Date: _____

Parent/legal guardian signature (if under age 18): _____ Date: _____