Authorization for Release of Health and/or Background Information

Student Name____
Last First Middle

Home Address____

Telephone____________________ Date of Birth_______________ SS#____________________

I, ________________________________ authorize Methodist College (MC) to
(Print Name)
disclose the following protected health and/or background information to:____________________

☐ **Complete Medical File**	☐ **I authorize the release of the following Highly Confidential Information**
☐ Health History	☐ Drug Screen Results
☐ Physical Exam	☐ Criminal Background Check
☐ Latex Allergy Screen	☐ DCFS Background Check
☐ Immunization Record	
☐ TB Record	☐ **Other**____________________

Term: This authorization will remain in effect:
☐ For 90 days from the date of this authorization
☐ Until MC fulfills this request
☐ Until student has graduated or otherwise is no longer enrolled at MC
☐ Other __________________________________

Purpose: The protected health and/or background information is being used or disclosed for the purpose of employment at MMCI and/or fulfillment of clinical site contracts.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that MC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health and/or background information.

I understand that I may revoke this Authorization by notifying MC, Office of Registrar in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by MC in reliance on or before I revoked it.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of MC treatment of me.

I understand that I may inspect or copy the protected health and/or background information to be used or disclosed as permitted under federal or state law.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health and/or background information. By my signature, I hereby knowingly and voluntarily authorize MC to use or disclose my health and/or background information in the manner described above.

______________________________________ __________________________
Student Signature Date

Note: If student is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

____________________ ____________________ __________
Signature of Legal Guardian or Relationship to Student Date

Other Legal Representative