



MOODY BIBLE INSTITUTE HEALTH SERVICE DEPARTMENT

Welcome to Moody!

Congratulations on your acceptance to Moody Bible Institute! Health Service is available to assist you with health concerns you may have as a student here at MBI. Our office hours are listed below.

All students enrolling at MBI are required to have all Health Forms submitted to MBI Health Service **by July 15th for Fall and January 1st for Spring Enrollment**. Since some Health Care Providers make appointments up to six weeks in advance, you will need to make your appointment as soon as possible. Please read the forms in their entirety before you call your physician's office for an appointment. Please ensure that all forms include your name and provider's signature, when required.

Please refer to the checklist for further instructions on completing the required health forms. If you have questions about these requirements or need to obtain additional forms, you may contact us at (312)-329-4417.

Students who have not completed their health records prior to arriving on campus will be required to complete them either in Health Service or at a local Health Clinic, at the student's own expense. **If you were previously a student at MBI please contact Health Service in order to determine what needs to be completed in order to update your Health Records.**

Health Service Staff is not able to answer questions about Student Health Insurance. Please contact the Student Health Insurance Coordinator at Moody Central (312)-329-2020 or studenthealthinsurance@moody.edu.

Please note that Health Service **will not disclose** your protected health information to any other Moody Department unless you sign a Medical Record Release Form.

Thank you for your prompt attention to the above matters to ensure the smoothest possible transition into your Moody Bible Institute student experience!

Sincerely,

Ann Meyer

Miss Ann Meyer, RN-BC, BSN, MHA
Administrator of Health Service

Phone: (312)-329-4417
Fax: (312)-329-4419
Email: healthservice@moody.edu

820 N LaSalle Blvd
Health Service Department
Chicago, IL 60610

Hours of Operation
Monday-Friday
9:30am-12:00pm
1:00pm-4:00pm

REQUIRED FOR CHICAGO CAMPUS

CHECKLIST FOR COMPLETION

Please read the directions in their entirety before completing the forms.

Questions about completion of these forms should be directed to the Health Service Department (312) 329-4417

1. Documentation Requirements

- Please **DO NOT** staple or paperclip your forms.
- Grad Students do not need to complete Part 6 (Part 6 is only required for Undergrad Students).
- Please write with a **black ball point pen only**.
- If you are going to send in your forms electronically, please scan and send your forms. **We will only accept forms in PDF format.**
- Your Health Care Provider must sign each form. **Please double check you have all required signatures before leaving the office.**
- Please **make a copy** of your Health Records for yourself before you mail them to us. **We are not responsible for records that are lost in the mail.**

2. Health Forms

- Part 1 asks for some information about you. Please fill out every part completely and sign.
- Part 2 is your immunization record. The state of Illinois requires that students have 2 doses of the MMR vaccine, 3 doses of the TDaP vaccine (with the most recent one within the past 10 years), and 1 dose of the Meningococcal Conjugate Vaccine (given after the age of 16 and before the age of 21). If you have an official copy of your immunization records, you may submit that copy. We do not offer the Meningococcal Conjugate Vaccine at Health Service, but students can get the MMR or TD/TDaP here for a fee.
 - If your doctor's office can give you an official copy of your immunization record, we will accept that in place of having your doctor fill out part 2. Please make sure your healthcare provider signs it.
- Part 3 must be completed before doing your Tuberculosis screening (part 4). Please fill out completely.
- Part 4 is your Tuberculosis (TB) Screening. Students have 2 options for completing the screening: a skin test and a blood test. All students must have a screening done less than 1 year before the start of classes. **International students and students traveling overseas must receive the screening 2 weeks after arriving back in the United States.** If that 2 weeks happens after the health form due date, please turn in the rest of your health forms by the due date and include a note stating when you will be able to do the screening. If needed, students can complete the screening on campus for a fee.
 - Students who do the blood test must provide a copy of the lab report with your health forms.
 - Students who have received the BCG vaccine must take the blood test.
 - If you have history of a positive TB Skin Test, you must provide documentation of the positive TB Skin Test, and show proof of completing treatment for latent tuberculosis.
- Part 5 is your confidential health history. Please place a check by any condition that applies to you and fill out all boxes completely. Please check the "none" boxes if nothing is applicable.
- Part 6 is your physical exam and must be completed by your physician.
 - Please make sure that part 6 is completely filled out and signed before leaving your doctor's office.
- Part 7 is the Health Insurance Portability and Accountability Act (HIPAA). Please read the attached explanation notice of privacy practices and then fill out the HIPAA form. Please note the explanation notice of privacy practices is for your records and does not need to be returned to us, we just need the HIPAA form.
- Attention International Students:** You will only turn in parts 1-2 and 5-7. Parts 3-4 will be completed after you arrive in the U.S.

3. Additional Information

- Any student who takes any injections in their room must come to Health Service immediately upon arrival to campus to arrange for proper disposal of sharps. These items cannot be disposed of in normal trash containers.
- Allergy Shots cannot be given on campus. Please Contact our office to make arrangements to receive them off campus.
- Failure to complete the Health Forms will result in a hold on your registration for the next semester. Students who have not completed their health records prior to arriving on campus will be required to complete them either in Health Service or at a local Health Clinic, at the student's own expense.**

Health Records are due in Health Service no later than July 15th for Fall & January 1st for Spring

REQUIRED FOR CHICAGO CAMPUS IMMUNIZATION RECORD

PART 1 – To be Completed By Student

Last Name	First	Middle	Student ID	Student Phone ()
Home Address			Date of Enrollment <input type="checkbox"/> Fall <input type="checkbox"/> Spring Year _____	<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate
City/State/Country/Zip or Postal Code			E-mail Address	
Date of Birth (mm/dd/yyyy)	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Other (specify)	F-1 International Student Visa <input type="checkbox"/> Yes <input type="checkbox"/> No
I hereby Authorize Moody Bible Institute Health Service to make this Immunization Record available to the Illinois Department of Public Health or its designated representative.				
Student Signature			Date of Signature	
Parent/Guardian Signature (if under 18)			Date of Signature	

PART 2 – To be Completed by a Health Care Provider*

REQUIRED IMMUNIZATIONS (dates required)

Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.

■ **MEASLES-MUMPS-RUBELLA** – 2 shots against measles, mumps, and rubella (exempt if born before 1/1/57)

MMR 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1	mm/dd/yy	OR	MEASLES (Rubeola) 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1	mm/dd/yy
	2	mm/dd/yy		MUMPS 2 doses at least 28 days apart AND after 12 months of age.	1	mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella.				RUBELLA 2 doses at least 28 days apart AND after 12 months of age.	1	mm/dd/yy
<input type="checkbox"/> Required lab report attached.					2	mm/dd/yy
Documentation of dates of disease IS NOT acceptable evidence of immunity against measles, mumps or rubella.					2	mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DTaP, TD, Tdap)**

3 or more doses of diphtheria, tetanus vaccine. One dose MUST be a Tdap.

*The most recent vaccine must have been administered within the last 10 years.

1 after 2 months of age <input type="checkbox"/> DTP / DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> TD ____/____/____	2 A minimum of 28 days after the first <input type="checkbox"/> DTP / DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> TD ____/____/____	3 REQUIRED Within 10 Years <input type="checkbox"/> Tdap ____/____/____
mm/dd/yy	mm/dd/yy	mm/dd/yy

■ MENINGOCOCCAL CONJUGATE VACCINE - The Meningococcal Conjugate Vaccine is REQUIRED after the age of 16 for all students 21 and younger. Menomune and Meningitis B do not meet this requirement.	1 mm/dd/yy
	2 mm/dd/yy

RECOMMENDED IMMUNIZATIONS (complete if received)

<input type="checkbox"/> HEPATITIS A	1	mm/dd/yy	2	mm/dd/yy
<input type="checkbox"/> HEPATITIS B	1	mm/dd/yy	2	mm/dd/yy
<input type="checkbox"/> VARICELLA	1	mm/dd/yy	2	mm/dd/yy
<input type="checkbox"/> OTHER (Specify)	1	mm/dd/yy	2	mm/dd/yy
			3	mm/dd/yy
				<input type="checkbox"/> Had Varicella Disease (Chickenpox)

Required Healthcare Provider Verification*

Provider Name (print or stamp)	Title	Signature	Date
Address	Phone	Fax	

*A "Health Care Provider" is defined as an M.D., D.O. or R.N, who is not a family member. It may also be an L.P.N or Medical Assistant who has had specific training in administering and reading Mantoux TB skin tests and Vaccines and who is directly supervised by an M.D. or R.N.

REQUIRED FOR ALL CHICAGO CAMPUS TUBERCULOSIS SCREENING

PART 3 – To be Completed by the Student

Last Name	First Name	Middle	Student ID	Date of Birth (mm/dd/yyyy)
If you answer YES to any of the questions, please describe			Answer	Explanation
1	Have you ever been told that you have an immune disorder or illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2	Have you received a live vaccine in the past 4 weeks? (i.e. measles, mumps, rubella, chickenpox, or shingles).		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3	Have you been outside the United States in the past 2 weeks, or will you travel outside the United States before coming to campus? (If YES, please wait 2 weeks after your return to the US to complete the test. Test can be completed on campus if needed.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Returned
4	Have you ever had a positive TB Skin Test? When?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
5	Have you ever been told by a healthcare provider that you had active TB?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Have you ever taken medications for TB? Which Medications? When?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide documentation
7	Have you ever had a BCG Vaccine for TB? (BCG does not exempt you from this requirement). If Yes, complete option 2 below.		<input type="checkbox"/> Yes <input type="checkbox"/> No	International students must complete screening in the USA or at Health Service
8	Were you born outside the United States? (If yes, Where?)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
9	Are you an International Student? (If yes, please list your home country).		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered "YES" to any of these questions STOP, Do not proceed to Part 4				
TB Screening (either TB Skin Test or IGRA blood test) is REQUIRED for ALL Students				

PART 4 – To be Completed by a Health care Provider* REQUIRED

Screening may include placement of Mantoux Skin Test or IGRA Blood Test. If you are unsure how to proceed please refer the student to MBI Health Service for their Required TB Screening.				
Option #1 Mantoux Skin Test (no history of BCG)		Option #2 IGRA Blood Test (history of BCG)	Option #2 IGRA Blood Test (history of BCG)	
PLACEMENT			Required for patients with history of BCG Vaccine	
An Intradermal TB skin test (Mantoux Method) was placed on <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Forearm			Type of IGRA Labs Drawn (Specify)	
Date mm/dd/yy	Time		Date mm/dd/yy	
READING			RESULT	
Measured result in millimeters of induration. If no induration state "none" or "0mm" Do not write "neg" or "negative"		<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Date mm/dd/yy	Time			Please Attach All Documentation Including lab and chest x-ray reports if completed
Health Care Provider Name		Title	Address	
Signature		Date (mm/dd/yy)	Phone () - () - ()	Fax () - ()

*A "Health Care Provider" is defined as an M.D., D.O. or R.N, who is not a family member. It may also be an L.P.N or Medical Assistant who has had specific training in administering and reading Mantoux TB skin tests and Vaccines and who is directly supervised by an M.D. or R.N.

REQUIRED FOR CHICAGO CAMPUS CONFIDENTIAL HEALTH HISTORY AND PHYSICAL EXAM

PART 5 – To be Completed By Student				
Last Name	First Name	Middle	Student ID	Date of Birth (mm/dd/yyyy)
Please check all conditions you had or currently have and explain details in the box provided.			Please list the following: Select "None" if Not Applicable	
<input type="checkbox"/> Acne <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Concussion <input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Epilepsy <input type="checkbox"/> Eye Problems <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Frequent Indigestion <input type="checkbox"/> GERD <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hernia <input type="checkbox"/> Hypertension <input type="checkbox"/> Insomnia	<input type="checkbox"/> Jaundice <input type="checkbox"/> Joint Pain <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Mono <input type="checkbox"/> Night Sweats <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Ulcers <input type="checkbox"/> Other (Specify)	Explanation (Name of Condition and Treatment Information) <div style="text-align: right;"><input type="checkbox"/> None</div>	
			Allergies (Please List Below) <div style="text-align: right;"><input type="checkbox"/> None</div>	
			<input type="checkbox"/> Epi-Pen (Expiration Date) __/__/____ <div style="text-align: right;"><input type="checkbox"/> None</div>	
			Surgeries (Operations) <div style="text-align: right;"><input type="checkbox"/> None</div>	
			Routine Medications and Supplements/Herbal Remedies <div style="text-align: right;"><input type="checkbox"/> None</div>	
			Permanent Disabilities <div style="text-align: right;"><input type="checkbox"/> None</div>	

PART 6 – To be Completed by a Physician*					
REQUIRED FOR UNDERGRAD STUDENTS ONLY					
Height	Weight	Appropriate Weight for Age/Height? <input type="checkbox"/> Yes <input type="checkbox"/> No	BP	Pulse	Blood Type (optional)
Physical Exam	Normal	Abnormal	Describe Abnormalities, Surgeries, Significant History		
Skin					
Eyes, Ears, Nose, Sinuses					
Mouth, Throat, Tonsils					
Cardiovascular					
Respiratory					
Gastrointestinal					
Genito-Urinary					
Endocrine					
Musculo-Skeletal System					
Nervous System					
Psychiatric					
Menstrual History (Female Only)			<input type="checkbox"/> Oral Contraceptives (Specify)		
Notes	Medications		Allergies		
If any current condition or prescribed medication requires monitoring by lab tests please send a copy of the most recent lab work					
Health Care Provider name	Title	Signature		Date	
Signature			Phone () ()	Fax () ()	

*May also be completed by a Nurse Practitioner or Physician's Assistant

**MOODY BIBLE INSTITUTE
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice, which became effective on January 1, 2010 applies to the Moody Bible Institute Health Service (MBI Health Service). The following pages are for your records and do not need to be returned to Health Service.

UNDERSTANDING YOUR HEALTH INFORMATION AND MEDICAL RECORD: This notice of Privacy Practices describes the privacy practices of MBI Health Service. MBI Health Service wants you to know that nothing is more central to our operations than maintaining the privacy of your Protected Health Information (“PHI”). PHI is information about you, including basic information that may identify you and relates to your past, present, or future health conditions, symptoms, exams, test results, diagnoses, treatment given, and a plan for future care or treatment. This medical information is used to plan your care and treatment and be a source of your health information.

YOUR HEALTH INFORMATION RIGHTS: Your medical record which contains your PHI is the property of MBI Health Service. Federal and Illinois laws provide you with the following rights regarding your PHI that is contained in the medical record that MBI Health Service keeps about you. These rights include the right to:

- obtain a copy of this Notice of Privacy Practices.
- request certain restrictions on the uses and disclosures of your PHI.
- request a copy of your health record.
- request an amendment to your health record if you believe it contains an error.
- obtain a list of people and companies to which MBI Health Service has released your health information.
- request that we communicate with you about your healthcare at a confidential phone number or address.
- revoke your written consent or authorization to use or disclose your health information except when the use or disclosure has already happened.
- receive notification of a breach of privacy or security of your PHI.
- provide access your electronic health record if your PHI is maintained electronically.
- report a breach relating to the privacy or security of your PHI.

Federal and Illinois law also provide you with the right to be informed about and give written authorization before any health information, including highly confidential information, is disclosed, unless such a disclosure is required by law. Examples of highly confidential information are mental health treatment, substance abuse or referral, developmental disability services, HIV/AIDS testing and treatment, venereal disease treatment, sexual assault treatment and testing and genetic testing information and results.

MBI HEALTH SERVICE'S RESPONSIBILITIES:

- Maintain the privacy of you health information as required by law.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Do what is required by the Federal and State law in effect at the time MBI Health Service discloses your health information.
- Notify you if we are unable to agree to your requested restriction on disclosure of your health information.

THIS NOTICE BECAME EFFECTIVE ON JANUARY 1, 2010.

Fall 2019

MOODY BIBLE INSTITUTE
NOTICE OF PRIVACY PRACTICES

- Agree to reasonable requests to communicate your health information by an alternative method or to an alternative location.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION: MBI Health Service will use your health information contained within the Health Service medical record to give you treatment, for you to receive reimbursement for your treatment, and to operate our health care businesses. We will not disclose your PHI to any health plan for payment or operations if you have paid out of pocket and in full for the services rendered.

EXAMPLES OF HOW YOUR HEALTH INFORMATION WILL BE USED OR DISCLOSED FOR TREATMENT, REIMBURSEMENT, AND OPERATIONS:

We will use your health information for treatment.

For example: Your physician, nurse and other member of your healthcare team will collect information about you in your medical record. We may disclose information to another health care provider who will be assuming your care, for immediate continuity of care. This health information will be used to choose the treatment they believe is best for you; members of the team will document in your medical record the actions they took and their observations of you. Your physician will then know how you are responding to the chosen treatment.

We will use your health information for you to receive reimbursement.

For example: We will send an itemized receipt that includes some of your health information to you to submit to the person responsible for the bill and to your third party payer (such as your Health Insurance Company or Medicare). In some instances, you may need to send a copy of part or all of your medical record to your third party payer. This information will be disclosed only upon completion of our request for medical records release form.

We will use your health information for our routine operations.

For example: Physicians, nurses, and other professionals will use your health information to review the treatment you received and its outcomes. They also may compare your treatment and outcomes to those of other patients like you. We compare cases to help us learn how to improve the quality and effectiveness of our health care services.

OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

MBI Health Service is enrolled in the Illinois Department of Public Health I-CARE (Illinois Comprehensive Automated Immunization Registry Exchange) program. We will use this program to enter and retrieve Immunizations.

Upon receipt of your written authorization to use and/or disclose your health information. We will use and/or disclose your health information to those persons or companies for which you give us your written authorization or permission to do so. If you authorize us to use or disclose your information, you must complete our request for medical records release form. A person who can verify your identity must witness and co-sign a request for medical records release form. You may revoke your authorization in writing at any time except to the extent that we have already used or disclosed your health information as you previously authorized. If your health information includes highly confidential information, we will only use and disclose such information, unless a disclosure is allowed or required by federal or Illinois law, after you have given written authorization to disclose your highly confidential information on our request for medical records release form.

MOODY BIBLE INSTITUTE
NOTICE OF PRIVACY PRACTICES

MBI Health Service may without your written authorization release your health information for the purposes described below.

Other Requests for Confidential Communications

You or your legal representative must tell MBI Health Service which of your relatives or other person(s) may receive information about you. After learning who these persons are, we may, in our best judgment, use and disclose your health information, except for your highly confidential information, to notify these persons of what they need to know to care for you. In an emergency or other situation where you are not able to identify your chosen person(s) to receive communications about you, we may exercise our professional judgment to determine whether such disclosure is in your best interest, who is the appropriate person(s) and what health information is relevant to their involvement with your health care.

Other Communication with You

We may contact you to remind you of appointments or to follow up on the services you received. We may leave messages about appointments or other reminders on your telephone or with the person who answers the phone, or send notices via email or the campus post office.

Business Associates

We provide some services through other persons or companies that need access to your health information to carry out these services. The law refers to these persons or companies as our Business Associates. We may disclose, as allowed by law, your health information to our Business Associates so that they can do the job we have contracted with them to do. We require that our Business Associates use appropriate safeguards to ensure the privacy of your health information. These Business Associates are also governed by Federal law relating to maintenance of your PHI in a confidential manner.

Health Oversight Activities and Specialized Government Functions

We may disclose your health information to an agency that oversees health care systems and ensures compliance with the rules of government health programs such as Medicare, Medicaid, or All Kids, and under certain circumstances to the U. S. Military or the U. S. Department of State.

Law Enforcement Officials, Medical Examiners, Coroners, and Court or Administrative Orders

We may disclose your health information to the police, other law enforcement officials, medical examiners and coroners, and to the courts or administrative proceedings as allowed or required by law, or required by a court order or other legal process.

Funeral Directors and Organ, Eye, and Tissue Organizations

We may disclose your health information to funeral directors as necessary to carry out their duties and as allowed by law; or to organ, eye, and tissue organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

Public Health Activities

We may report your identity and other health information to any one of the following: public health authorities for the purpose of controlling disease, injury or disability; to the U.S. Food and Drug Administration for regulating certain products or activities; to government authorities about suspected or known child abuse or neglect, elder abuse and neglect, or domestic violence; to a person exposed to a contagious disease or has risk of contracting or spreading a disease; to your employer and government agencies as required by federal and state laws regarding work-related illness or injury; to prevent or lessen a serious or imminent threat to a person's or public's health or safety; or, to a public or private entity that is authorized to assist in disaster relief efforts.

**MOODY BIBLE INSTITUTE
NOTICE OF PRIVACY PRACTICES**

Research

We may use or disclose your health information to identify you as a potential candidate for a research study that has been approved by an Institutional Review Board or for governmental research studies in which your identifiable information will not be released.

Marketing

MBI Health Service will not use or disclose your health information without your written consent for marketing purposes.

Workers Compensation

We may disclose your health information as allowed or required by Federal and Illinois law relating to workers' compensation or to other similar programs.

Other Uses of Your Information

MBI Health Service may provide you with face-to-face or other communication about products or services related to your treatment, case management, care coordination, alternative treatments, therapies, health care providers, or care settings.

RIGHT TO FILE A COMPLAINT

If you would like to report a privacy problem please contact:

**Benefits Manager, Human Resources
Moody Bible Institute
820 N. LaSalle Blvd.
Chicago, IL 60610
(312) 329-4297**

If you would like further clarification or additional information, please contact:

**Health Service, Moody Bible Institute
820 N. LaSalle Blvd.
Chicago, IL 60610
(312) 329-4417**

If you believe your privacy rights have been violated, you may file a complaint with Moody Bible Institute, Director of the Office of Civil Rights (OCR), or the U. S. Secretary of Health and Human Services (HHS). We will not retaliate against you if you file a complaint with us, the OCR, or with the HHS.

Disclaimer:

We reserve the right to change our privacy practices and to use a new Notice of Privacy Practices. If MBI Health Service changes its practices, a new Notice of Privacy Practices will be available upon your request, by mail or in person at MBI Health Service. This Notice of Privacy Practices has been adopted as the only approved Notice for use throughout MBI Health Service. Any changes are unauthorized and invalid.