INFORMATION RELEASE CONSENT FORM FOR SPECIAL EDUCATION AND RELATED SERVICES

SUPPORTS ACCESS TO PUBLIC BENEFITS/INSURANCE

STUDENT NAME:	STUDENT DATE OF BIRTH:
SCHOOL DISTRICT/CHARTER SCHOOL:	

I hereby authorize this school _____ to release this student's records and information to Medicaid for the purpose of billing for special education and related services that may be provided to this student under 34 CFR part 300.

By checking YES and signing this authorization document, I understand and agree that:

- My signature on this form permits the above-mentioned school and/or school district/charter school to use this student's and/or my public benefits or insurance information to pay for services under 34 CFR part 300, which outlines special education and related services under the Individuals With Disabilities Education Act;
- My signature is voluntary and services are not dependent on my authorization;
- My signature is valid until such time that it is revoked;
- I can revoke my approval at any time by writing to the originating agency, which revocation will be valid upon receipt, but which will not affect actions taken prior to receipt of such revocation;
- I have a right to request and receive from the school district or charter school a copy of the records that have been given to Medicaid; and
- I have a right to receive a copy of this consent form.
- Requesting the use of these funds DOES NOT affect this student's rights/your rights to a fair, appropriate public education nor does it cost you or your family money. There will be no co-pays, no loss of Medicaid eligibility and no impact on lifetime Medicaid benefits as a result of this consent.

By checking NO and signing this document, I am refusing the use of these funds.

- I understand that I have the right to refuse the permission to use these funds to pay for services under 34 CFR part 300, which are special education and related services under the Individuals with Disabilities Education Act.

☐ YES, I give the school permission to share this student's education and health-related information with Medicaid, including billing information.

☐ NO, I do not give the school permission to share this student's education and health-related information with Medicaid

Signed by (check only one): ☐ Student (if over 18 years of age) ☐ Parent ☐ Guardian ☐ Custodian

Student Signature (*if over 18 years of age*)_____

Print Name: _____ Date: _____

Parent/guardian Signature (*if student is younger than 18 years of age*):_____

Print Name:_____ Date: _____