PARENTAL CONSENT TO RELEASE INFORMATION AND TO ACCESS PUBLIC BENEFITS OR INSURANCE (MEDICAID) FOR SPECIAL EDUCATION AND RELATED SERVICES

STUDENT:	DATE OF BIRTH:

I,_____, parent/guardian/custodian (circle one)

of_____, hereby authorize the _____School District/Charter School (circle one) to release my child's records or information about the special education and related services that may be provided to my child to Medicaid for the purpose of billing for special education and related services under 34 CFR part 300.

In signing this authorization, I understand and expressly agree that:

- This authorization permits the above-mentioned school district to use my child's and/or my own Medicaid information to pay for services under 34 CFR part 300, which are special education and related services under the Individuals With Disabilities Education Act;
- This authorization is voluntary and services are not dependent on my authorization;
- This authorization is valid until such time that it is revoked;
- This authorization may be revoked 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 above-mentioned school district a copy of the records that the school district has disclosed to Medicaid; and
- I have a right to receive a copy of this authorization.

Parent/Guardian/Custodian (circle one) Signature: _____

Printed Name: _____ Date: _____