

SCHOOL DISTRICT

CHILD'S NAME:

**CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID
REIMBURSEMENT
FOR
HEALTH RELATED SUPPORT SERVICES**

_____ as parent/guardian of
(parent or person in parental relationship)

_____ gives permission to disclose
(child's name) (date of birth)

information from my child's educational records to local, state and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services included in my child's Individualized Education Program (IEP).

Signature: _____ **Date:** _____
(parent or person in parental relationship) (month-day-year)

