SCHOOL DISTRICT NAME

CONSENT FOR RELEASE OF INFORMATION AND MEDICAID REIMBURSEMENT

Student Name: ___________________________ Grade: ____________ DOB: ____________ ID#: _____________

Parent or Guardian Name: ____

PARENTAL CONSENT TO DISCLOSE STUDENT INFORMATION TO THE STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH CARE FINANCING AND POLICY

The NAME OF DISTRICT provides School Health Services to children who have an Individualized Education Program or a Plan of Care at no cost to our parents/guardians. Federal Medicaid funds are available to school districts to help cover the costs of providing these necessary services. To access these funds, the District participates in the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) Medicaid School Health Services program. Billing the Medicaid program for your child's services will not affect your family's Medicaid insurance benefits and is at no cost to your family.

School districts can request reimbursement from Medicaid for eligible School Health Services, such as speech, occupational and physical therapy, nursing services, and school-based mental health services. In order to seek the Federal funds, the District must disclose information to DHCFP from those student's education records for which reimbursement is sought. The information that must be disclosed includes the student's name, date of birth, and information regarding the service that was provided, such as the date, type, and duration of service. Upon request, you may receive copies of records disclosed to DHCFP.

The District requests your consent to disclose information from your child's educational records to DHCFP, only as necessary, for the District to seek Medicaid funds to help cover the costs of the School Health Services the District provided to your child. Whether or not you give your consent or if you withdraw your const, the District will continue to provide necessary School Health Services to your child at no cost to you, the parent/guardian.

STUDENT'S NAME: ____
(First) (Middle Initial) (Last)

Please review the statements below and select your opinion by checking the appropriate box.

☐ Yes. As the parent/guardian of the student named above, I give my consent to the District to disclose information form my child's education records to DHCFP only as necessary to allow the District to seek Medicaid funds to help cover the costs of the School Health Services provided to my child.

I understand that my consent will remain in effect until I withdraw it, and that I may withdraw my consent at any time by notifying the District. If I withdraw my consent, the District will continue to provide School Health Services provided to my child. I understand that allowing the District to seek Medicaid funds will not affect covered services proved to my child by community providers.

☐No. As the parent/guardian of the student named above, I do not give my consent to the District to disclose information from my child's education records to DHCFP.

I understand that if I do not give consent, the District will continue to provide necessary School Health Services to my child at no cost to me, the parent/guardian and the District will be unable to recover costs for these services from Medicaid.

Name: ______________________________ Signature ______________________________ Date_____________
(Name of parent/guardian) (Signature of parent/guardian (month-day-year)

SAMPLE