**explanation**: A new federal regulation allows districts to obtain parent consent on a one time basis for medicaid billing purposes. additional consent will not be necessary.

**FINANCIAL IMPLICATIONS**: Use of this form will save staff time and facilitate more timely receipt of medicaid reimbursements to the district.

# STUDENTS 09.14 AP.24

Release/Inspection of Student Records/Medicaid Consent

To Third Party

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The **Grant County** Schools are hereby authorized to: 🞊 Release or copy 🞊 Permit the inspection of

the records listed below for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who was born on

***Student’s Name***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The individual or agency to whom this information is to be released

 is **Medicaid--KSBA**.

I understand that the records affected are checked below, along with the reason(s) for the requested release

or authorization to inspect.

|  |  |
| --- | --- |
| **RECORDS** | **PURPOSE** |
| ⭘All cumulative records |  |
| ⭘ Attendance record only |  |
| ⭘ Grade records only |  |
| ⭘Standardized test data only |  |
| 🞊 Special education records only | **Medicaid Billing/Audit Purposes** |
| ⭘ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

This release is effective only for the specified records or types of records on hand as of the date you sign

below UNLESS you specifically authorize further release of the specified records or types of records

as follows. (Check and initial **ONE** of the following.)

🞊 I authorize **on-going release** of the specified records or types of records to the entity/individual specified

 until student reaches age of 18 unless earlier revoked in writing. (Initials \_\_\_\_\_\_)

⭘ I authorize release of the specified records or types of records until the end of the present school year

 (June 30th) unless earlier revoked in writing. (Initials \_\_\_\_\_\_)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

***Signature of Parent/Guardian or Individual Acting as Parent under FERPA\* Date***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

***Signature of Student, 18 or Older or Attending Post-secondary Institution*** ***Date***

\*Living in the student’s home in the absence of the parent on a day-to-day basis

Medicaid Consent

🞊 I have received my Annual Notification of Parent Rights regarding Medicaid billing, and I understand and agree that the District may access my child’s or my public benefits or insurance to pay for services under the Individuals with Disabilities Education Act. (This also authorizes release of education records as specified above.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

***Signature of Parent/Guardian Date***