2018-2019
Parent Release of Information

Student Name: _____Birthdate: _____SSID: _____

I consent for Special Services Cooperative of Wamego to release records or information about my child's participation in services to participating physicians, other health care providers, the Kansas Department of Health and Environment (KDHE), any KDHE billing agents, and any school billing agent, as necessary, to process claims for reimbursement by KDHE for covered health-related services, evaluations for these services and transportation, on the day the student receives any health-related service, which are outlined in the child's Individualized Education Program (IEP), including duration and frequency of IEP services.

Physician's Name: _____

Contact Information: _____

Procedural Safeguards:

- I understand that the Cooperative may be required to provide certain health-related services to a student who has an IEP at no additional cost to the student's parent(s), and that my refusal to sign this form will not affect whether such services are provided at no cost to the student named above.
- I understand that I will not be required to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. I understand that my child's Medicaid benefits will not be used if that use will:
    - (a) decrease available lifetime coverage or any other insured benefit; (b) result in your family paying for services that would otherwise be covered by a public benefit or insurance program and that are required for the child outside of the time the child is in school; (c) increase premiums or lead to the discontinuation of benefits of insurance; or (d) risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
- I understand and agree that the school is requesting consent to access the child's or parent's public benefits or insurance to pay for services under 34 C.F.R. part 300.
- I also understand that the granting of consent is voluntary and may be withdrawn at any time. If I later revoke consent, that revocation is not retroactive (i.e. it does not negate any action that has occurred after the consent was given and before the consent was revoked).
- I understand that for mandatory Medicaid auditing, reporting and claiming purposes, the Public Consulting Group, a service provider of the Kansas Department of Health and Environment, will likely request information including your student's full name, date of birth, unique Kansas Identifier Number (KIDS Number) and school identity.

I understand all of the statements set forth above and I hereby grant all of the above referenced permissions for the duration of services within your agency.

PARENT(S)/GUARDIAN(S) SIGNATURE(S)

_____ DATE:_____

- For the time period of July1, 2018 to June 30, 2019.