

Parent Release of Information

Student Name: _____ Birthdate _____

Permission is given for the Tri-County Interlocal LEA to share appropriate information concerning the above listed student with the Kansas Health Policy Authority so the LEA, can, if applicable, seek reimbursement for any health-related services that are claimable under the Title XIX Medicaid Program or the Title XXI State Child Health Insurance Program.

In conjunction with the above, I understand that the LEA may also need to obtain a "Physician's Prescription" for some/all of the health-related services that is provided to the student. In this regard, I hereby give permission for the LEA, if applicable, to share portions of the student's Individual Education Plan (IEP) with a qualified health care professional or the Tri-County Special Education Medicaid Medical advisor in order to obtain such "Physician's Prescriptions".

Physicians Name:

Contact Information:

I understand that the LEA is required to provide certain health-related services to any student who has an IEP at no additional cost to the student's parent (s)/guardian(s). I also understand that my signature- or failure to sign this form- will not affect whether such services are provided to the student.

I understand all of the statements set forth above * and I hereby grant all of the above * referenced permissions for the period from July 1, 2009 through June 30, 2010.

PARENT(S)/GUARDIAN(S)SIGNATURE(S) _____
DATE ____/____/____

PHYSICIAN AUTHORIZATION

Dear Health Care Provider:

As specified in the student's, Individual Education Plan (IEP), the student qualifies to receive one or more of the following services during the time period that is specified in that IEP.

- | | | |
|------------------|-------------------------|-------------------------|
| Audiology | Occupational Therapy | Physical Therapy |
| Nursing Services | Speech/Language Therapy | Attendant Care Services |

If/as appropriate, the LEA may seek reimbursement from the Kansas Health Policy Authority for some/all of the above-listed services. In order to do that, however, the LEA must obtain the signature of a qualified health care provider.

Your signature certifies that the student qualifies to receive all of the above-listed service that are specified in the student's IEP. In this regard, this document will serve as the required "Physician's Prescription" with respect to those services.

Signature _____ Date ____/____/____

For the period from July 1, 2009 through June 30, 2010