

2011-2012

HIGH PLAINS EDUCATIONAL COOPERATIVE

Parent Release of Information

Student Name: _____ Birthdate _____

Permission is given for the High Plains Educational Cooperative #611 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 in order to obtain such "Physician's Prescriptions".

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, 2011 through June 30, 2012.

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

DATE ____/____/____

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
Nursing Services

Occupational Therapy
Speech/Language Therapy

Physical Therapy
Psychological Services
Counseling 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, 2011 through June 30, 2012