Clark County School District
Student Services Division

CONSENT FOR RELEASE OF INFORMATION AND MEDICAID REIMBURSEMENT

Student Name: _____ Grade: _____DOB:_____ ID#_____

Parent's 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 Clark County School District (District) provides school-based child health services to children with an Individualized Education Program (IEP) 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-based child health services (SBCHS) program.

School districts can request reimbursement for eligible school-based child health services, such as speech, occupational and physical therapy, and nursing 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.

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

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

STUDENT'S DATE OF BIRTH _____

Please review the statements below and select your option 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 from 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-based 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-based health services to my child at no cost to me, the parent/guardian.

☐ 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 my consent, the District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

Name:_____
(Name of parent/guardian)

Signature:_____ Date: _____
(Signature of Parent /guardian) (Month-day-year)

Distribution: Original – Confidential Folder 1st Copy – Parent/Guardian/Adult Student

CCSD
CLARK COUNTY
SCHOOL DISTRICT