MSB SCHOOL SERVICES

EHS Education Health Services

Permission to Exchange Information (Medicaid to Schools)

Student Name: _____

Student's Date of Birth: _____ School District of Liability: _____

Name of Parent or Legal Guardian: _____

Name of Receiving Medical Facility: Education Health Services LLC

Consent Active For 12 Months From Date Signed

I (the parent/guardian of the above-named student) give consent to my child's school district and/or personnel connected with my student's educational placement to exchange information and communication related to services being provided to my child for the purpose of obtaining an authorized order for medically necessary services. Such exchanged information could include order forms, care plan(s), evaluation information, and other relevant supporting documentation necessary for licensed health care providers to make informed decisions regarding ordered services in an educational setting.

The school district and the medical professional will exchange only the records essential for the purposes of signing and ordering medically necessary services and the above individuals will only review the documents necessary to perform their assigned tasks.

Consent to this exchange of information is voluntary. I understand that if I refuse to give consent, this will only affect the district's ability to receive reimbursement through Medicaid. My refusal does not relieve the school district of its responsibility to provide services, per my student's plan of care, at no cost to me. I understand that I may revoke this consent to release information for Medicaid billing at any time however this cannot be retroactive. this will only affect the district's ability to receive reimbursement through Medicaid.

Printed name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____