

**Northwest Kansas Educational Service Center  
Authorization for Use and/or Disclosure of Protected Health Information**

Student Legal Name:  
Medicaid ID#:  
School Year:

Date of Birth:  
SSN#:

Please allow the school to copy or send a copy of your child's Medicaid Card with this form.

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1. I hereby authorize NKESC 602, its employees, agents, and assigns to use and/or disclose the protected health information identified in paragraph 3, below, as set forth herein.

2. I authorize the following physician(s) and/or agency to disclose the information identified in paragraph 3, below, to NKESC 602:

\_\_\_\_\_  
*Name(s) of authorized person(s)*

\_\_\_\_\_  
*Address* *City* *State* *Zip Code*

\_\_\_\_\_  
*Name(s) of authorized person(s)*

\_\_\_\_\_  
*Address* *City* *State* *Zip Code*

3. The information which I am authorizing to be used and/or disclosed is (where applicable, identify the date of service or type of treatment): Diagnosis of my child's medical condition.

4. I authorize the information identified in paragraph 3, above, to be used and/or disclosed for the following purpose(s): Provide appropriate services and to assist the school district to receive funds from Medicaid to assist in paying for designated special education services.

5. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

\_\_\_\_\_ I understand that this authorization is voluntary and that I may refuse to sign it.

\_\_\_\_\_ I understand my signature on this form will assist NKESC 602 in receiving funds from Kansas Medicaid to help pay for special education services..

\_\_\_\_\_ I understand NKESC 602 is responsible for providing special education and related services as listed on my child's IEP at no cost to me.

\_\_\_\_\_ I understand I may revoke this authorization at any time by notifying NKESC 602 in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization.

\_\_\_\_\_ I understand health records, once received by the school district, will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

\_\_\_\_\_ I understand once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

\_\_\_\_\_ I understand NKESC 602 will release information, upon request, to the following agencies and their agents or contract service providers: Student's Doctor/Health Care Provider, Kansas Medicaid Agency, Kansas Department of Health and Environment, Kansas State Department of Education.

I, the undersigned, do hereby swear that I am the parent or a legal representative of the above mentioned student. I have read and understand the above information and consent to the release of this information to the agency(cies) listed above.

\_\_\_\_\_

*Printed Name of Legal Representative*

*Description of Legal Representative's Relationship to Student*

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*Date*

*Signature of Parent / Legal Representative*