South Country Central School District

CENTRAL REGISTRATION
189 Dunton Avenue
East Patchogue, NY 11772
631.730.1617
631.758.4637 (fax)
www.southcountry.org

Date ____________________

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AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

STUDENT'S NAME: ________________________________ DOB: ________________

Authorization is granted by the undersigned for the release of ALL official records, files and data directly related to the above named student to:

Jack Colombo
Interim Director of Student Support Services
South Country Central School District
2714 Montauk Highway
Brookhaven, NY 11719

Please forward all relevant medical records (including immunizations), psychological/triennial, psychiatric, educational, social history, speech reports, OT/PT evaluations and the current IEP to Student Support Services office as soon as possible.

________________________________ ________________________________
Signature of Parent/Guardian *Relationship*

Address:

____

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South Country Central School District

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East Patchogue, NY 11772
631.730.1617
631.758.4637 (fax)
www.southcountry.org

Date: ____________________

Student Name: ____

District: South Country Central School District

I hereby give my consent for my child, __________________, to be evaluated by the South Country Central School District for the purpose of providing current cognitive, achievement and/or functional information to the Committee on Special Education (CSE) for the review of my child's current Individualized Educational Program (IEP). I understand that I will receive a copy of the results of any and all evaluations that are given to my child.

Signature: _________________________ Date: _________________
(Parent or person in parental relationship)

BOARD OF COOPERATIVE EDUCATIONAL SERVICES
EASTERN SUFFOLK BOCES

Instructional Support Center
Special Education Division
15 Andrea Road
Holbrook, NY 11741

Date: ______________________

Student Name: ____

District: South Country Central School District

I hereby grant consent for the above-named student to be enrolled in a BOCES special education class.

____
Signature of Parent/Guardian

__________ YES, I hereby give permission for my child to be seen by the BOCES physician for a screening physical.

__________ NO, I do not give permission for my child to be seen by the BOCES physician. I understand it is my responsibility to provide a physical so that my child can enter BOCES program.

____
Signature of Parent/Guardian

BOARD OF COOPERATIVE EDUCATIONAL SERVICES
EASTERN SUFFOLK BOCES

Instructional Support Center
Special Education Division
15 Andrea Road
Holbrook, NY 11741

Date: ______________________

Student Name: ____

District: South Country Central School District

I hereby grant consent for the above-named student to be evaluated for the purposes of developing an Individualized Education Plan (IEP).

____
Signature of Parent/Guardian

South Country Central School District

CENTRAL REGISTRATION
189 Dunton Avenue
East Patchogue, NY 11772
631.730.1617
631.758.4637 (fax)
www.southcountry.org

Re: Consent for Release of Information to Access Medicaid Reimbursement for Health Related Services

Dear Parent/Guardian:

The South Country Central School District participates in the Student Supportive Health Service Program. The district receives funding from the New York State Department of Health for support services your child/children may receive in our schools (i.e. counseling). The funds we receive help to lower the school district's tax rate.

The use of your child's Medicaid Number IN NO WAY AFFECTS ANY OTHER BENEFITS you may be collecting from the Department of Health and/or other agencies.

We request your signature at the bottom of the attached Consent Form for your child's records (medical and otherwise), which are open for review.

Thank you for your cooperation.

Sincerely,

Jack Colombo
Interim Director of Student Support Services

Attached: Consent Form for Release of Information for Medicaid Reimbursement.

South Country Central School District

CENTRAL REGISTRATION
189 Dunton Avenue
East Patchogue, NY 11772
631.730.1617
631.758.4637 (fax)
www.southcountry.org

CONSENT FOR RELEASE

DATE:________________

STUDENT'S NAME: ________________________________ DOB: _________________

I hereby request and authorize The South Country Central School District to release any relevant medical, psychological, psychiatric, school records pertaining to the case of the above named student to ______________________________.

________________________________ ________________________________
Signature of Parent/Guardian *Relationship*

Address:

____

____

____

South Country Central School District

TOWN OF BROOKHAVEN - COUNTY OF SUFFOLK

STUDENT SUPPORT SERVICES
2714 Montauk Highway
Brookhaven, NY 11719
631-730-1781
Fax: 631-286-4914

Dear Parent:

Re: Parental Consent for Release of Educational Information for Medicaid Funding

Federal and State regulations require school districts, such as South Country, to obtain written parental consent prior to the disclosure of education records in connection with the District's application for reimbursement of Medicaid reimbursable IEP special education expenses.

Recently, school districts have been directed by the New York State Education Department to use the attached consent form each time an IEP special education service changes.

In order to allow South Country Central School District to recover Medicaid reimbursement funds for IEP services, kindly complete this form.

If you should have any questions regarding this matter, please do not hesitate to contact Ann Scala at 730-1783.

Sincerely,

Jack P. Colombo
Interim Director
Student Support Services

Enclosure

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT

PARENTAL CONSENT FOR RELEASE OF EDUCATIONAL INFORMATION FOR MEDICAID FUNDING

TERMS, RIGHTS AND RESPONSIBILITIES

By signing this application, I understand and confirm that:

- I have been fully informed in my native language or other mode of communication that the granting of my consent to share information for the purpose of obtaining Medicaid reimbursement for the services provided per my child's individualized education program (IEP) is voluntary and may be revoked at any time and that if I revoke my consent, it does not negate (undo) an action that occurred after my consent was given and before my consent was revoked.

- If I refuse consent to allow use of Medicaid insurance to pay for special education services, the school district must still provide all required special education services at no cost to me.

- The use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program

- I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I, ____, as parent/guardian of
(Print name of parent or person in parental relationship)

____,
(Print child's name)

give permission to the public agency (school district, municipality or Medicaid provider) to use Medicaid to pay for IEP services and to such public agency and to each approved private special education school or provider who provides IEP services to my child to disclose information regarding diagnosis and procedure codes for billing Medicaid for services described in my child's IEP and for evaluations in relation to the services; and in the event of an audit, documentation required to support services reimbursed by Medicaid from my child's educational records to local, State and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for covered health-related support services for each service and for each school year in which service is provided as recommended in my child's IEP if my child is or becomes Medicaid-eligible.

I give my consent voluntarily and understand that I may withdraw that consent at any time. I also understand that my child's entitlement to a free and appropriate public education (FAPE) is in no way dependant on my granting consent.
Signature: ______________________________ Date: ____________