

<p><b>Board of Education</b></p> <p><b>President</b> GREGORY C. MIGLINO, JR.</p> <p><b>Vice President</b> CARL MOODT</p> <p>JOE CIPP VICTOR CORREA TONI HUFFINE JAMES JANKOWSKI KEVIN KIRK MARIAN McKENNA BARBARA SCHATZMAN</p>	<p style="text-align: center;"><i><b>South Country Central School District</b></i></p> <p style="text-align: center;"><b>CENTRAL REGISTRATION</b> 2714 Montauk Highway Brookhaven, New York 11719 631.730.1617 631. 286.9404 (fax) <a href="http://www.southcountry.org">www.southcountry.org</a></p>	<p style="text-align: center;"><b>INTERIM SUPERINTENDENT OF SCHOOLS</b></p> <p style="text-align: center;">MR. RAYMOND WALSH 631-730-1510 FAX 631-286-6394</p> <p style="text-align: center;"><b>Assistant Director of Student Support Services</b> Danielle Colby</p>
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Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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:

*Ann Marie Morreale  
Director of Student Support Services  
South Country Central School District  
189 Dunton Avenue  
East Patchogue, NY 11772*

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:*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<p><b>Board of Education</b></p> <p><b>President</b> GREGORY C. MIGLINO, JR.</p> <p><b>Vice President</b> CARL MOODT</p> <p>JOE CIPP VICTOR CORREA TONI HUFFINE JAMES JANKOWSKI KEVIN KIRK MARIAN McKENNA BARBARA SCHATZMAN</p>	<p><i><b>South Country Central School District</b></i></p> <p><b>CENTRAL REGISTRATION</b> 2714 Montauk Highway Brookhaven, New York 11719 631.730.1617 631. 286.9404 (fax) <a href="http://www.southcountry.org">www.southcountry.org</a></p>	<p><b>INTERIM SUPERINTENDENT OF SCHOOLS</b></p> <p>MR. RAYMOND WALSH 631-730-1510 FAX 631-286-6394</p> <p><b>Assistant Director of Student Support Services</b> Danielle Colby</p>
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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)

# 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

<p><b>Board of Education</b></p> <p><b>President</b> GREGORY C. MIGLINO, JR.</p> <p><b>Vice President</b> CARL MOODT</p> <p>JOE CIPP VICTOR CORREA TONI HUFFINE JAMES JANKOWSKI KEVIN KIRK MARIAN McKENNA BARBARA SCHATZMAN</p>	<p><i><b>South Country Central School District</b></i></p> <p><b>CENTRAL REGISTRATION</b> 2714 Montauk Highway Brookhaven, New York 11719 631.730.1617 631. 286.9404 (fax) <a href="http://www.southcountry.org">www.southcountry.org</a></p>	<p><b>INTERIM SUPERINTENDENT OF SCHOOLS</b></p> <p>MR. RAYMOND WALSH 631-730-1510 FAX 631-286-6394</p> <p><b>Assistant Director of Student Support Services</b> Danielle Colby</p>
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*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,

Ann Marie Morreale  
Director of Student Support Services

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

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**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:*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 appropriate public education (FAPE) is in no way dependant on my granting consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_