Form MED
July 1, 2010

Aiken County Public Schools

Consent for Treatment, Release of Information, and Medicaid Reimbursement

The Aiken County School District (the District) and the State Department of Education have my permission to provide health-related services to my child and to release and exchange medical and other confidential information, as necessary, to the Department of Health and Human Services and any third party insurance carrier regarding health-related services provided to my child prior to the date of this consent or thereafter for services that the school district/agency will provide in the future.

By signing this form, I give the District and the State Department of Education my permission to bill Medicaid and any third party insurance and receive payment from Medicaid or any third party insurer for health-related services as set forth in my child's individualized education program (IEP), and for psychological evaluation services, nursing services, and other health-related treatment services billable to Medicaid without the requirement of an IEP.

I understand that Medicaid reimbursement for health-related services provided by the District and the State Department of Education will not affect any other Medicaid services for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether I enroll my child in public or private benefits or insurance programs. I also understand that my refusal to allow access to the Department of Health and Human Services or any third party insurance carrier does not relieve the District of its responsibility to ensure that all required services are provided at no cost to me.

I understand that the granting of consent is voluntary on my part and may be revoked at anytime. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

I also understand that the District and the State Department of Education will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of health-related services.

______________________________	______________________________
Student's Name	Student's Date of Birth
______________________________	______________________________
Medicaid #	SS #
______________________________	______________________________
Signature of Parent/Guardian	Date