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| **School District/Public Agency** |  **Consent to Release Information and Access Private Insurance Benefits**34 C.F.R. §300.154(e) |
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| **Name of Student** | **Birthdate** | **Date**  |
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A school district or public agency may use a child’s private insurance plan to provide or pay for health and health related services as permitted by a private insurance plan and documented in the student’s Individualized Education Program (IEP). A parent must be fully informed about the type, frequency and duration of the IEP services in order to bill the private insurance plan. Parent permission must be voluntary. A school district or public agency must obtain informed parent consent before a private insurance plan is accessed for special education or related services in the student’s IEP. *Note that informed parent consent must be obtained each time the school district or public agency seeks to access private insurance. Also, the parent must sign a new consent form if special education or related services are amended before the school district or public agency may access private insurance for the amended IEP services.*

**Please provide the following information:**

Child’s Insurance Carrier:

Policy and/or Group Number:

Policy Holder’s Name:

Policy Holder’s Address:

Policy Holder’s Phone Number(s) Home: \_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_

**This consent has two parts:**

1. Consent for disclosure of your child’s personally identifiable information to your private insurance company and/or health care providers as follows:

Consent to release educational records and/or information about my child’s participation in special education and related services to participating physicians, other health care providers, as necessary to process claims for reimbursement for covered health-related services, evaluations for these services, and transportation as outlined in my child’s IEP.

1. Consent to access private insurance as follows:

The school district or public agency may use my child’s private insurance to pay for special education and related services outlined in my child’s IEP.

**My informed consent pertains to the following services:**

The school district or public agency has identified the following services that my child will receive, the dates covered and the code for the type of service.

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| --- | --- | --- |
| Services | Dates/Duration | Provider |
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**The following Procedural Safeguards pertain to my consent:**

* I understand that the school district or public agency may provide certain health-related services pursuant to my child’s IEP at no additional cost to me, and that my refusal to sign this form will not affect whether special education and related services are provided at no cost to my child.
* I understand that I will not be required to incur an out-of-pocket expense, such as the payment of a deductible or co-pay amount, incurred in filing a claim for services. If any out-or-pocket charges occur, the school district or public agency will pay those costs.
* I understand that my child’s private insurance benefits will not be used if that use will:
	+ Decrease available lifetime coverage or any other insured benefit;
	+ Result in charges to me for services that would otherwise be covered by our private insurance plan when such services are required for my child outside of the time my child is in school; or
	+ Increase premiums or lead to the discontinuation of benefits of insurance.
* I understand that granting consent is voluntary and may be withdrawn at any time. If I later revoke consent, that revocation is not retroactive (i.e. it does not negate any action that has occurred after the consent was given and before the consent was revoked).
* I understand that the school district or public agency cannot require me to dispute or appeal a denial of private insurance benefits on behalf of my child.

**[ ]  I give my consent for the school district or public agency to release education records or information as described above, AND I give my consent to access my child’s private insurance benefits to pay for the above listed special education and/or related services.**

**[ ]  I DO NOT give my consent.**

**Sign, date and return as soon as possible.**

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

Your consent is voluntary and may be revoked at any time.

***School District or Public Agency Use***

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| **Date received:** | **Signature of School District or Public Agency Official** |
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