Kenai Peninsula Borough School District
148 North Binkley Street
Soldotna, AK 99669

Name of Student: _____

Date of Birth: _____

Name of Parent/Guardian: _____

Is this student currently eligible for Medicaid or Denali Kid Care Benefits? ☐ YES ☐ NO
Has this student ever been eligible for Medicaid or Denali Kid Care Benefits? ☐YES ☐ NO

Parent/Guardian Authorization for Release of Information

I, _____, parent/guardian _____
Please print your name *Please print student's full name*

give permission to the Kenai Peninsula Borough School District to release information to the Department of Health and Social Services, the Alaska Medicaid agency, regarding services my child receives through the District's special education program. This information is for the sole purpose of obtaining federal reimbursement to our district for the cost of eligible health-related special education services your child receives.

I hereby authorize the use or disclosure of health care and/or information as described above. I understand that this authorization is voluntary. I understand that these records may contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individual(s) or district releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or district releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or district authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization will expire when the child is no longer receiving Medicaid billable health related services, unless you revoke your authorization.

_____ _____
Parent/Guardian signature *Date*

_____ _____
Student's Medicaid Number *Student's Social Security Number*

This release may be revoked at anytime: Please contact KPBSD @ 714-8881 for appropriate paperwork.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

07/20lh