Authorization for Insurance & Education Information

Patient/Student Name:_____ Date of Birth: _____

I hereby authorize JAG KY to exchange health and education information/ records for the purpose listed below

The information to be disclosed consists of:

Student Name: _____ Date of Birth: _____

Home Address: _____

Insurance name (MCO): _____ Subscriber/Member ID:_____

This information will be used for the following purpose(s):

1. Educational evaluation and program planning

2. Assessment and planning for JAG KY competencies in school.

3. To determine Medicaid eligibility for JAG KY program

4.Other:_____

_____

Authorization This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

*If a minor student is authorized to consent to medical insurance information without parental consent under federal or state law, only the student shall sign this authorization form.