Parent Release of Information

Child Name: ____ Birthdate: ________________________

Child's Social Security #: ______________________ Child's Medicaid #: ____________________________

Permission is given for the **Northeast Kansas Infant-Toddler Services** ECI to share appropriate information concerning the above listed student with the Kansas Healthy Policy Authority so the ECI, can, if applicable, seek reimbursement for any health-related services that are claimable under the Title XIX Medicaid Program or the Title XXI State Child Health Insurance Program.

In conjunction with the above, I understand that the ECI may also need to obain a "Physician's Prescription" for some/all of the health-related services that is provided to the child. In this regard, I hereby give permission for the ECI, if applicable, to share portions of the child's Individual Family Service Plan (IFSP) with a qualified health care professional in order to obtain such "Physician's Prescriptions."

Physician's Name: ____
Contact Information:____

I understand that the ECI is required to provide certain health-related services that is provided to the child who has an IFSP at no additional cost to the child's parent(s)/guardian(s). I also understand that my signature - or failure to sign this form - will not affect whether such services are provided to the child.

I understand all of the statements set forth above -- and I hereby grant all of the above -- referenced permissions for the period from July 1, 2010 through June 30, 2012.

PARENT(S)/GUARDIAN(S) SIGNATURE(S)
____ DATE ______/_______/_______

....

Dear Health Care Provider:

As specified in the child's, Individual Family Service Plan (IFSP), the child qualifies to receive one or more of the following services during the time period that is specified in that IFSP.

If/as appropriate, the ECI may seek reimbursement from the Kansas Health Policy Authority for some/all of the above- listed services. In order to do that, however, the ECI must obtain the signature of a qualified health care provider.

Your signature certifies that the student qualifies to receive all of the above-listed service that are specified in the child's IFSP. In this regard, this document will serve as the required "Physician's Prescription" with respect to those services.

PHYSICIAN SIGNATURE ____ Date ______/______/_______
For the period from July 1, 2010 through June 30, 2012

Audiology	Nursing Services	Dietitian Services
Occupational Therapy	Speech/Language Therapy	Case Management (Family Service Coordination)
Physical Therapy	Counseling Services	Development Intervention