Consent to Release Information

Colorado school districts are entitled by law to seek Medicaid reimbursement when the districts provide services to Medicaid-eligible students. The following consent form is to authorize the Lake County School District to release to Colorado Health Care Policy and Financing information related to Medicaid services provided to the student identified below as necessary to apply for and recover Medicaid reimbursement.

NOTE: Participation in the school Medicaid reimbursement program does NOT adversely affect the student's eligibility for future Medicaid services in any way.

I give consent and authorize the Lake County School District to release to Colorado Health Care Policy and Financing (HCPF) information related to health and other Medicaid eligible services the district provides to the student identified below during the _____ school year, as frequently and comprehensively as necessary to apply for and recover Medicaid Partial Reimbursement for such services.

_____ _____
Student Name Student's Date of Birth

_____ _____
Student's School Student's Medicaid Number

_____ _____
Parent/Guardian Name (or Student Over 18) Student's Social Security Number

_____ _____
Parent/Guardian Signature (or Student Over 18) Date

If at any time you wish to revoke this permission, please contact _____.

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