CONSENT FOR RELEASE OF INFORMATION

TO ACCESS MEDICAID REIMBURSEMENT

SSI RECIPIENTS

I, _____, as parent or legal guardian of_____

Parent/Legal Guardian ***(child's name)***

grant permission to The Children's Center at United Cerebral Palsy Association of Greater Suffolk, Inc. to release information contained in my child's educational records to local, state and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for evaluation services, and/or health-related education services included in my child's Individual Education Plan ("IEP").

_____

Signature of Parent or Legal Guardian

_____

Date

HS12(6/16)