

Stanfield School District 61

Code: **EHA-AR**
Adopted: 11/16/04
Readopted: 4/10/08
Orig. Code(s): EHA-AR

Authorization to Disclose Educational Records to Oregon’s Medicaid Agency

Student Name: _____ DOB _____

School Name: _____ Number _____

School Contact Person: _____ Grade: _____ Gender _____

I understand that:

1. The district may disclose my child’s personally identifiable information to the Oregon Medical Assistance Program (OMAP) to determine eligibility for Medicaid reimbursement for medical services my child receives in school settings.
2. If my child is eligible for Medicaid reimbursement, the district may disclose additional information including diagnosis and treatment codes for billing purposes.
3. This authorization is voluntary and I may refuse to sign it without affecting my child’s health care or educational program.
4. I may revoke this authorization at any time by notifying the district in writing. I understand that is revocation will not apply to information that has already been released in response to this authorization.
5. Information disclosed to OMAP may not be shared with any other party without the written consent or authorization of the parents, guardians, surrogate or student (if over 18), unless otherwise authorized by law.

I consent to the disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited.

This authorization is good for one year from (date signed) _____

Signature of Parent/Legal Guardian/Student	Relationship	Date