

## Parent Release of Information

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Permission is given for the tiny-k Early Intervention Program to share appropriate information concerning the above listed student with the Kansas Health Policy Authority so that tiny-k E.I., 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 tiny-k E.I. may also need to obtain 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 tiny-k E.I., 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 tiny-k E.I. is required to provide certain health-related services to any child who has an IFSP at no additional cost to the child's parents(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, 2009, through June 30, 2011.

Parent(s)/Guardian(s) signature(s): \_\_\_\_\_

Date: \_\_\_\_\_

Medicaid Billing Information

Child's Name: \_\_\_\_\_

*(as it appears on the Medical card)*

Medicaid Number: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_

Child's Birthdate: \_\_\_\_\_ Sex: M or F

Child's current address: \_\_\_\_\_  
\_\_\_\_\_

Parent's Name: \_\_\_\_\_

Foster Parent's Name: \_\_\_\_\_

Name of Child's Doctor: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_

Doctor's Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
*(include area code)*