CONSENT FOR INSURANCE BILLING AND RELEASE OF STUDENT RECORDS

Federal and state laws allow local educational agencies to file for insurance benefits to pay for health services provided in the educational setting. Seeking claim reimbursement **will NOT impact** your child's overall insurance cap or deductible. Parents/guardians must consent to the release of education and or health/medical records to file for insurance benefits claims. Please complete the information below:

I, _____**[Parent/Guardian],** on behalf of _____[**Student]**, **[Date of Birth]** _____ hereby authorize the **Westminster School District** to release Student's records to file for insurance benefits claims.

□ I decline to consent for the release of my child's education and medical/health information for the purposes of filing for insurance benefits to pay for the care my child receives while at school.

Records to be released may include:

- Student's Name; date of birth; gender; insurance information; the date, time and type of health services provided; and the rendering provider.
- My child's behavioral, medical, health and/or education records.

Primary Insurance:

Name of Insurance Provider	Identification Number	Group Number
Student's Address	**Subscriber's Full Name**	**Relation to Student**

Secondary Insurance:

Name of Insurance Provider	Identification Number	Group Number
Student's Address	**Subscriber's Full Name**	**Relation to Student**

Certification: I hereby certify I am the legal guardian of the student named herein. I hereby consent to the release of the above-mentioned student records for the purpose of submitting claims to my child's insurance provider for reimbursement of health services provided in the school setting. I further agree to hold the District and its officers, agents and employees harmless and I expressly waive any right I may have to institute legal proceedings against the District, its officers, agents or employees based upon any disclosure of the student records identified herein. I understand that I have a right to request a copy of any student record that I have given consent to disclosure.

Signature of Parent/Guardian: _____
Printed Name of Parent/Guardian: _____

Date:_____

This consent is issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA) (45 CFR §§ 164.502, 164.506, 164.520) and the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g: 34 C.F.R. part 99). Consenting Party acknowledges and agrees that Protected Health Information (PHI) may be used for billing purposes without additional authorization in accordance with HIPAA (45 CFR § 164.20), and Notice of Privacy Practices must be provided to explain its use.