Twin Hills School District

APPLE BLOSSOM | K-5
ORCHARD VIEW | K-12
SUNRIDGE | K-8
TWIN HILLS | 6-8

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Consent for Exchange of Health Insurance Information for Funding Purposes

By completing the Consent for Exchange of Health Insurance Information for Funding Purposes form, you help our school district access state and health-plan funding that supports free mental health and wellness services for students. **Providing your child's insurance information allows the district to seek reimbursement for services already offered at school - at no cost to you.** This will not affect your child's insurance coverage, result in any charges to your family, or change your child's eligibility for services, including special education support. While all students will continue to receive no-cost services, completing this form helps ensure our schools can sustain and expand these vital programs for students and families. **This is not a consent for services.**

Parental Consent

- **Only the appropriate health records from my child's educational records will be released by the district** to Paradigm Healthcare Services, LLC., and Carelon Behavior Health for the limited purpose of billing Medi-Cal or a commercial healthcare insurance provider.
- The records will be shared electronically with Medi-Cal and DHCS third-party administrators for reimbursement, **all information will be kept confidential in accordance with FERPA and HIPAA privacy laws**, **and it will not be shared with any other parties without your written consent unless otherwise permitted by law.**
- **I will not be charged for these services.** This will not limit my community-based services.
- My consent is valid for one year. **It is voluntary and it can be revoked at any time.** Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so, and delivered to CRPUSD. The revocation will be effective upon receipt of the written request but will not be effective to the extent that CRPUSD may have acted in reliance upon this authorization prior to the revocation.
- I will not be required to sign up or enroll in public benefits or insurance programs.
- **My consent will not affect any insurance or benefits myself or my child receives.**
- I have the right to request that this consent be provided in my native language, or through another mode of communication, if feasible.
- I have a right to obtain a copy of this authorization.

☐ **I consent to the release of my student's records, and access to their benefits, for billing purposes only. (MUST COMPLETE REVERSE)**

☐ **I do not consent to release my student's records to access for billing purposes. I understand CRPUSD will not be able to recoup fees for services provided. This will NOT affect my child's ability to receive services through the district. (Must complete Student & Parent Info on reverse).**

Student Information

Student's Legal First Name	
Student's Legal Last Name	
Date of Birth (MM/DD/YYYY)	
Student has an IEP (circle)	YES NO
My student has health insurance (circle)	YES NO

Insurance Information

Do not complete if opting out

Is the insurance provider Medical/Medicaid	YES NO
Name of Insurance Provider (Disability, or Commercial Healthcare Ins. Provider)	
Student Ins. ID # / Member ID # / or BIC (MediCal) #	
Policy Holder/Subscriber First Name	
Policy Holder/Subscriber Last Name	
Policy Holder/Subscriber Relationship to Student	

Signature:

Full Name of Parent/Guardian submitting this form:_____

Relationship to Student: _____

Parent/Guardian Signature: _____

Date: _____

Please return this form to your school office.