

BOX 1 All parents/representatives please provide the following information.

Child's Last Name: Click or tap here to enter text. **First Name:** Click or tap here to enter text. **Middle Initial:** Click or tap here to enter text.

Birth Date: Click or tap here to enter text.

School: Hiawatha Valley Education District

Home Address: Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip: Click or tap here to enter text.

Parent/Representative name(s): Click or tap here to enter text.

Relationship: Click or tap here to enter text.

The district is asking your permission to share information with the Department of Human Services (DHS) in order to bill for services provided. Information shared would be: your child's name, date of birth, member number, dates of service, and codes indicating type of service. In the case of an audit by DHS or the US Dept. of Health and Human Services (DHHS), the data shared may also include your child's IEP/IFSP, evaluation reports, service and attendance records.

You may request copies of all information we share with DHS or DHHS. You may change or stop your decision to share the information at any time by written request. If you choose NOT to give information or sign this release, your child's IEP/IFSP services will not change or be discontinued. If you choose not to share information the district will not receive compensation from MA or MNCR. Services may be provided in one or more of the following areas:

Assessment/Evaluation (for IEP determination)
Occupational Therapy Services
Assistive Technology Devices
Interpreter Services
Mental Health Services

Nursing Services
Personal Care Assistance
Physical Therapy Services
Special Transportation
Speech/Language/Hearing Therapy

BOX 2

Your child's Minnesota Health Care ID #: Click or tap here to enter text.

My signature verifies that I have received information regarding the third-party billing process and that I AGREE to share the information required for this process.

The district may share information back one year from today and continue forward as long as my child is eligible for special education.

Parent/Legal Representative signature: Click or tap here to enter text.

Date: Click or tap here to enter text.

BOX 3

We do not use Medical Assistance

Parent/Legal Representative signature: Click or tap here to enter text.

Date: Click or tap here to enter text.