

**CONSENT FOR RELEASE OF INFORMATION
TO ACCESS MEDICAID REIMBURSEMENT**

SSI RECIPIENTS

I, _____, as parent or legal guardian of _____
Parent/Legal Guardian *(child's name)*

grant permission to The Children's Center at UCP to release information contained in my child's educational records to local, state and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for evaluation services, and/or health-related education services included in my child's Individual Education Plan ("IEP").

Signature of Parent or Legal Guardian

Date