RELEASE OF INFORMATION FORM TO ASSIST PARENTS IN OBTAINING HEALTH AND DENTAL INSURANCE COVERAGE FOR THEIR CHILDREN ATTENDING AUBURN ENLARGED CITY SCHOOL DISTRICT

The purpose of this release is to allow the Cayuga County Health and Human Services (CCHHS) Department, Auburn Enlarged City School District (AECSD), and the Booker T. Washington Center (BTW) to better assist you and your children to get and maintain health and dental coverage through the Public Insurance Program (Medicaid).

By signing this release you will be allowing CCHHS, AECSD, and BTW to share the confidential information listed below. This information may be further disclosed to the Cayuga County Health and Human Services Department and the local facilitated enrollers at BTW so they can also assist in ensuring your child(ren)'s uninterrupted coverage. A facilitated enroller is someone who can assist you to enroll in a health insurance plan or dental insurance coverage. **The information will only be shared to the extent that it is necessary or helpful to achieve this goal.**

The information disclosed will be limited to:

- My name and names of persons living in the household
- Dates of birth
- Address
- Phone number
- Gender
- Last four digits of Social Security Number for those applying for, or in receipt of Medicaid coverage
- Eligibility Status for Health and Dental Insurance, Temporary Assistance, Food Stamps, Day Care, HEAP Medicaid, including eligibility periods
- Status of School enrollment

Child's name: _____ SS# *_____ DOB _____ School _____
(last four digits)

Child's name: _____ SS# *_____ DOB _____ School _____
(last four digits)

Child's name: _____ SS# *_____ DOB _____ School _____
(last four digits)

My child(ren) currently has ***health*** insurance with _____
(*name of insurance company)*

My child(ren) currently has ***dental*** insurance with _____
(*name of insurance company)*

☐ My child(ren) have NO ***health*** insurance at this time. ☐ My child(ren) have NO ***dental*** insurance at this time.

RELEASE

I hereby give CCHHS, AECSD, and BTW permission to share the above information between themselves on my behalf. I also give permission for AECSD to share this information to CCHHS and BTW, only to the extent of helping me get or maintain health and dental coverage. I understand that any information released on my behalf may not be further disclosed without my express written permission.

I may revoke (cancel) this release at any time by writing to AECSD, Caren Radell, Nurse Supervisor, 78 Thornton Ave., Auburn, NY 13021. Such revocation will not affect any previous actions already taken.

_____ _____
(*Signature of Parent/Guardian or Student over 18)* *(Date)*

_____ _____
(*printed name)* *(relationship to student)*

_____ _____
(address) *(phone number)*

☐ I do not wish to participate in this insurance program.

*optional