Health Information Exchange & Consent Form

Humboldt County Office of Education participates in the ***LEA Medi-Cal Billing Option*** and ***Child & Youth Behavioral Health Initiative (CYBHI) Fee Schedule*** programs that fund essential health and mental health services for students. By providing your consent, you allow us to secure funding from Medi-Cal or private insurers to help cover these services at no cost to you. **You will never be charged for services your student may receive.**

Your consent allows **Paradigm Healthcare Services, LLC.**, our billing partner, to securely share necessary records with Medi-Cal or the CYBHI Fee Schedule third-party administrator(s) ("TPAs"). All information is handled confidentially and protected under federal privacy laws, including FERPA and HIPAA.

Student Information (Please Complete)

Student's Legal Name: _____ _____
First Name *Last Name*

Student's DOB: _____
MM/DD/YYYY

Primary Insurer: _____
Full Name of Health Plan (e.g. "Blue Shield, Medi-Cal")

Primary Policy Holder: _____ _____
First Name *Last Name*

Policy/Member ID: _____
If covered by Medi-Cal, use BIC number

Group Number: _____

Consent Options (Please Check One)

Please review the information below and indicate your consent.

- The sharing of information outlined in this agreement will be done in compliance with the Family Education Rights Privacy Act of 1974 ("FERPA"), as required under Title 34 Code of Federal Regulations, Title 20 of the United States Code, Section 1232(g), and Title 34 Code of Federal Regulations, Section 99.
- Only the appropriate health records from my child's educational records will be released by the district and Paradigm Healthcare Services, LLC., to bill Medi-Cal or the CYBHI Fee Schedule program.
- The records will be securely shared with Medi-Cal and DHCS (TPAs) for reimbursement, and all information will be kept confidential in accordance with FERPA and HIPAA privacy laws.
- I understand that I will never be charged for these services.
- I understand that my consent is voluntary and can be revoked at any time.

☐ **I consent** to the release of my child's records and access to their benefits for billing purposes.

☐ **I do not consent** to the release of my child's records for billing purposes.

Signature: _____ **Date:** _____

Full Name: _____ **Relationship to Student:** _____