Medical Record #_____
Edited: 3-2026

SUN PROJECT - CABARRUS

CLIENT AUTHORIZATION TO USE AND DISCLOSE HEALTHCARE, SUBSTANCE USE DISORDER TREATMENT, AND OTHER INFORMATION

I,_____, date of birth _____ , authorize the agencies, organizations, and individuals designated in this form to share the information identified below for the purposes described in this form. I authorize this information sharing so that these agencies, organizations, and individuals may work together—as the Substance Use Network (SUN)—to plan, coordinate, and provide treatment and other services for me, my unborn child, and my other children, if I have other children. (If I am carrying more than one child in utero during my pregnancy, then the term "child" means "children." The term "my other children" means children other than my unborn child for whom I have the authority to make healthcare and other decisions.)

A. WHO MAY SHARE INFORMATION:

I authorize the following agencies, organizations, and individuals to use, communicate, and disclose to one another the information identified in **Section C** of this form:

- Cabarrus Health Alliance
- Cabarrus Partnership for Children
- Cabarrus County EMS and its Community Paramedic Program
- Cabarrus County Department of Social Services
- Atrium Health
- North Carolina Department of Adult Correction (NCDAC)
- McLeod Addictive Disease Center
- Daymark Recovery Services
- Partners Health Management
- Endless Opportunities
- The Suda Institute and people it contracts with to help coordinate the work of the Substance Use Network

Collectively, the agencies, organizations, and individuals named in this **Section A** are referred to in this form as the "**SUN Partners**." I understand that by authorizing information sharing between and among the SUN Partners designated above, I am also authorizing information sharing between and among the personnel within each agency or organization who have a need for the information in connection with their duties that arise out of the provision and coordination of treatment and other support services for me and my child.

B. PURPOSE OF INFORMATION SHARING:

This authorization permits the SUN Partners to take a coordinated, multisystem approach to my care and treatment by sharing and using information for case management, care coordination, and for the following purposes:

1. To evaluate my need for healthcare and support services, and to coordinate and provide such services during my pregnancy, delivery, and after the birth of my child.
2. To assess my need for substance use and mental health treatment services, and to coordinate and provide such services during and after my pregnancy.
3. To protect my health, safety, and welfare, while supporting my success in substance use treatment.
4. To plan for the needs of my unborn child and, if I have other children, my other children.
5. To protect my child's health, safety, and welfare, and the health, safety, and welfare of my other children, if any.
6. To assess my child's and, if I have other children, my other children's need for medical services and childcare services, and to provide, manage, and coordinate these services.
7. To assess my need, my child's need, and my other children's need for social services and other support services and to make referrals and reports for obtaining those services.
8. To provide, manage, and coordinate social services and other services for me, my child, and my other children, if any.
9. To improve service and treatment outcomes for me, my child, and my other children.
10. To establish and continue financial assistance or other payment for services for me, my child, and, if I have other children, my other children.
11. To assess the quality and effectiveness of SUN services.
12. To improve service and treatment outcomes for pregnant women and children who are served by the Substance Use Network and its SUN Partners.

C. INFORMATION TO BE SHARED:

I authorize the SUN Partners designated above to use, communicate with, and disclose to one another the following information about me for the purposes described in **Section B** of this form.

- My name, address, date of birth, phone number, and other personal identifying information.
- My healthcare information, including medical history and the identity of any past and present providers of healthcare, mental health, and substance use disorder treatment.
- Information relating to any medical care and treatment provided to me during pregnancy, delivery, and after the birth of my child.
- My psycho-social history, including family and social history, relationship status, social supports, work and living environment, and history of psychiatric, medical, and substance use conditions.
- My housing information, including the stability, affordability, safety conditions, and adequacy of my housing; the identity of other household members and their relationship, if any, to me and my child; and who has legal control, through lease or ownership, of my right to live there.
- My alcohol and/or drug use treatment information, including but not limited to assessments, diagnosis, history, attendance, progress, medications, counseling, behavioral therapies, medication assisted treatment, treatment plans, and discharge summaries.
- My mental health treatment information, including but not limited to assessments, diagnoses, history, attendance, progress, medications, counseling, behavioral therapies, treatment plans, and discharge summaries.
- My lab test results, including drug screening and testing results.
- My WIC program applicant and participant information. (WIC means the Special Supplemental Nutrition Program for Women, Infants, and Children.)

- My history of involvement, if any, with the Cabarrus County Department of Social Services including any child health and safety assessments conducted before or during my participation in SUN Project services that relate to any of my children.
- My criminal history and current involvement, if any, with the North Carolina Department of Adult Correction, including any information relating to probation or parole.
- My jail status in the event I am held in the Cabarrus County Jail, including any information relating to or identifying health, mental health, and substance use disorder conditions and treatment while in jail.
- My developmental disabilities assessments and service information, including service plans and discharge summaries.
- My reportable communicable disease information, including any information about HIV, sexually transmitted infections, hepatitis, and tuberculosis.
- My financial information, including health plan or health benefits information.
- Other (specify):
  _____.

D. NOTICE OF VOLUNTARINESS:

- I understand that I have the legal right to refuse to sign this authorization form. If I choose not to sign this form, I understand that healthcare providers and health plans cannot deny or refuse to provide treatment, payment for treatment, enrollment in a health plan, or eligibility for health plan benefits because of my refusal to sign.
- I understand that signing this form is not a condition of eligibility for the WIC Program and refusing to sign this form will not affect my application or participation in the WIC Program.
- I understand that if I do not sign this form permitting the SUN Partners listed in **Section A** to share information, then in some instances, these SUN Partners may not be able to work together as the Substance Use Network to coordinate services for me, my child, and my other children, if any.

E. CONFIDENTIALITY:

There are several confidentiality laws that limit the disclosure of my information without my consent. Among them are:

- a federal health privacy law (the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Pts. 160 & 164), generally known as “HIPAA,” governing healthcare information.
- a federal law governing records of treatment for substance use disorder (42 C.F.R. Part 2), also known as the substance use disorder or “SUD law.”
- a North Carolina law governing mental health, developmental disabilities, and substance use disorder treatment information (G.S. 122C), sometimes called the “state mental health law.”

My healthcare information is protected by HIPAA. I understand that once health care information relating to me or my child is disclosed pursuant to this signed authorization, the HIPAA privacy law may not apply to the person receiving my information and, therefore, HIPAA may not prohibit the recipient from redisclosing the information to others.

However, when a SUN Partner receives information pursuant to this authorization about my treatment for substance use disorder or information that identifies me as having a substance use disorder, they may not redisclose it to anyone else except as permitted by this authorization or as otherwise permitted or required by the SUD law and the state mental health law.

In some situations, the SUD law permits a SUN Partner that is covered by HIPAA to redisclose my SUD information in accordance with the permissions contained in the HIPAA regulations. However, the SUD law prohibits SUN Partners who receive my SUD treatment information pursuant to this authorization from using or disclosing this information for any civil, criminal, administrative, or legislative proceeding against me unless I sign a separate consent form, or a court enters an order, authorizing such use and disclosure.

This form does <u>not</u> include using or disclosing substance use disorder treatment information for any civil, criminal, administrative, or legislative proceedings against me. My substance use treatment information cannot be used or disclosed for these purposes without me, through my written consent, or a court, through a court order, authorizing my information to be used for these purposes.

F. REVOCATION AND EXPIRATION:

I have the right to revoke this authorization at any time except to the extent that a SUN Project Partner, authorized by this form to disclose information, has already taken action in reliance on it. I may revoke this authorization by signing the ACT TO REVOKE section of this form and submitting it to one of the SUN Project Partners named and checked above in **Section A**. In addition, I may revoke this authorization with respect to a provider of healthcare, mental healthcare, or substance use disorder treatment services by following the procedures described in that provider's "Notice of Privacy Practices."

"If I do not revoke this authorization sooner, this authorization expires upon the following date or event:

_____ *[client must identify a date or event]."*

SIGNATURES ON FOLLOWING PAGE

SIGNATURE PAGE FOR AUTHORIZATION FORM

I have read and understand the contents of this authorization form.

_____
Name of Client (Please Print)

_____ _____
Signature of Client Date

- ***If the client (adult or minor) is consenting to treatment services on their own, then only the client may authorize disclosure of information relating to that treatment.***
- ***If a parent or other legally responsible person for a minor client is consenting to the client's substance use disorder treatment, then both the minor and the legally responsible person must sign the consent form.***
- ***If the client is an adult who has been adjudicated incompetent by a court, authorization to disclose must be given by the client's guardian or other legally responsible person.***

If the client is a minor or incompetent adult for whom a parent, guardian, custodian, or other legally responsible person is providing consent to treatment:

_____
Name of Parent or other Legally Responsible Person for the Client (Please Print)

_____ _____
Signature of Parent or other Legally Responsible Person for the Client Date

Describe authority to act on behalf of the client (check one):

___ I am the client's parent. ___ I am the client's guardian. ___ I am the client's legal custodian.

___ I am the client's health care agent named in a health care power of attorney. ___ Other.

_____
Name and title of SUN Project Partner staff member witnessing the signature(s) above. (Please Print)

_____ _____
Signature of SUN Project Partner staff member witnessing the signature(s) above. Date

The individual(s) signing this authorization must be given a copy of the signed authorization.

This Authorization will be kept on file by the Cabarrus Health Alliance or by another SUN Partner on behalf of the SUN Project.

Rev. Date: _____	ACTION TO REVOKE	

[Use either A or B below]

A. WRITTEN REVOCATION

I hereby give notice that the authorization to disclose information relating to _____
Name of SUN client

signed by me _____ on _____ is revoked, effective _____.
Print name of person who signed authorization *Date of authorization* *Date*

_____ _____
Signature of person who is revoking authorization *Date*

B. VERBAL REVOCATION

I, _____, attest that a verbal declaration was made on
Print name of SUN Partner staff member receiving revocation

_____ by _____to revoke this authorization
Date of verbal revocation *Print name of client or legally responsible person*

to disclose information relating to _____.
Print name of client

_____ _____
Signature of SUN Partner staff member receiving revocation *Date*