Medical Record #_____

SUN PROJECT - ROWAN

CLIENT AUTHORIZATION TO USE AND DISCLOSE CHILD'S HEALTHCARE AND OTHER INFORMATION

[TO BE SIGNED BY PARENT OR OTHER LEGALLY RESPONSIBLE PERSON AFTER BIRTH OF CHILD]

I,_____, date of birth _____ , authorize the agencies, organizations, and individuals designated in this form to share information about the child 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—to plan, coordinate, and provide treatment and other services for me and the following child of mine who is receiving services from the Substance Use Network (SUN).

_____/_____
name of child date of birth of child

If I birthed multiple children during my participation in the SUN Project, then the term "child" in this document will mean "children," and include the following:

_____/_____
name(s) of child(ren) date(s) of birth of child(ren)

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
- Rowan County Department of Social Services
- Rowan County Public Health Department
- Rowan-Salisbury School System
- Atrium Health
- North Carolina Department of Adult Correction (NCDAC)
- McLeod Addictive Disease Center
- Daymark Recovery Services
- Vaya Health
- Endless Opportunities
- Families First
- Novant Health
- Terrie Hess Child Advocacy Center
- 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 the care and treatment of me and my child by sharing and using information for case management, care coordination, and for the following purposes:

1. To evaluate my need and my child's need for healthcare and support services, including medication management and behavioral services, and to coordinate and provide such services.
2. To assess my need for substance use and mental health treatment services, and to coordinate and provide such services.
3. To protect my health, safety, and welfare, while supporting my success in substance use treatment.
4. To protect my child's health, safety, and welfare.
5. To assess my child's need for—and to provide, manage, and coordinate my child's—medical, behavioral, neurobehavioral, and developmental services, including any medication, treatment, or services for neonatal abstinence syndrome, neonatal opioid withdrawal, fetal alcohol spectrum disorder, or other effects of prenatal substance exposure.
6. To assess my need, and my child's need, for social services and other support services and to make referrals and reports for obtaining those services.
7. To provide, manage, and coordinate social services, childcare services, and other services for me and my child.
8. To improve service and treatment outcomes for me and my child.
9. To establish and continue financial assistance or other payment for services for me and my child.
10. To assess the quality and effectiveness of SUN services.
11. To improve service and treatment outcomes for pregnant women and children who are served by the Substance Use Network and its SUN Partners.

If I have other children for whom I have the authority to make healthcare and other decisions, and if these other children are receiving SUN services, the SUN Partners may use the information listed in **Section C** about my child named on page 1 of this form to carry out any of the purposes listed above for my other children.

C. INFORMATION TO BE SHARED:

Medical Record #_____

I authorize the SUN Partners designated above to use, communicate with, and disclose to one another the following **information relating to my child** (the child named on page 1) for the purposes described in **Section B** of this form.

- Name, address, date of birth, phone number, and other personal identifying information.
- Healthcare information, including any care and treatment for medical, behavioral, neurobehavioral, and developmental needs, and the identity of any providers of healthcare.
- Treatment, care, medication, and other services for prenatal substance exposure, including for neonatal abstinence syndrome, neonatal opioid withdrawal, fetal alcohol spectrum disorder, or other effects of prenatal substance exposure.
- Psycho-social history, including family and social history, parentage, social supports, and living environment.
- Housing information, including the stability, affordability, safety conditions, and adequacy of my and my child's 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.
- Mental health treatment information for emotional disturbance or other mental conditions, including but not limited to assessments, diagnoses, history, attendance, progress, medications, counseling, behavioral therapies, treatment plans, and discharge summaries.
- Lab test results, including drug screening and testing results.
- WIC program applicant and participant information. (WIC means the Special Supplemental Nutrition Program for Women, Infants, and Children.)
- 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.
- Information relating to developmental disabilities or delays, including assessments, service plans, and discharge summaries for infants with prenatal substance exposure.
- Reportable communicable disease information, including any information about HIV, sexually transmitted infections, hepatitis, and tuberculosis.
- 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 to my child 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 and my child.

Medical Record #_____

E. CONFIDENTIALITY:

There are several confidentiality laws that limit the disclosure of my child's 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 child's healthcare information is protected by HIPAA. I understand that once health care information relating to 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, to the extent that my child may receive treatment for substance use disorder, SUN Partners receiving information as permitted by this authorization about my child's treatment for substance use disorder 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 child's SUD information in accordance with the permissions contained in the HIPAA regulations. However, the SUD law prohibits SUN Partners who receive my child's SUD treatment information pursuant to this authorization from using or disclosing this information for any civil, criminal, administrative, or legislative proceeding against my child 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 the SUD patient. My child's 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 child's 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 or mental healthcare 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:

Medical Record #_____

_____ *[parent or other legally responsible person must identify a date or event].”*

SIGNATURES ON FOLLOWING PAGE

Medical Record #_____

SIGNATURE PAGE FOR AUTHORIZATION FORM

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

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

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

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

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

_____
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 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: _____

Medical Record #_____

	ACTION TO REVOKE	

[Use either A or B below]

A. WRITTEN REVOCATION

I hereby give notice that the authorization to disclose information relating to _____
Print name of juvenile(s)

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 Project Partner staff member receiving revocation

_____ by _____ to revoke this authorization
Date of verbal revocation *Print name of person revoking authorization*

to disclose information relating to _____.
Print name of juvenile(s)

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