SUN PROJECT

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, to plan, coordinate, and provide treatment and other services for me and my unborn child and, after my child is born, for me and my child. (If I am carrying more than one child in utero during my pregnancy, then the term "child" means "children.")

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, a public health authority and provider of healthcare, pregnancy care, the SUN Clinic, and other services.
- Cabarrus Partnership for Children, a provider of health, early education, and family outreach services.
- Gina Hofert, Shadale Jacobs, Victoria Manning, Barbara Sheppard, Rebecca Paige Grubb, and Asma Warrich, each in their respective roles as contractors of the Cabarrus Partnership for Children providing services to the SUN Project.
- Cabarrus County Department of Human Services, a provider of child welfare and other services for children and families.
- Atrium Health, a health care organization and network of medical practices, behavioral health centers, hospitals, and other medical facilities under the Charlotte-Mecklenburg Hospital Authority
- North Carolina Department of Adult Correction (NCDAC), the state agency responsible for prisons, community supervision, healthcare, and rehabilitation and reentry programs and services for adult criminal offenders.
- Genesis A New Beginning, a provider of mental health and substance use disorder services.
- McLeod Addictive Disease Center, Inc., a provider of outpatient, residential, and medication assisted treatment programs for substance use disorders.
- Daymark Recovery Services, a provider of services for the treatment of mental illness, substance use disorders, and developmental disabilities.
- Rowan County Department of Social Services, a provider of child welfare and other services for children and families.
- Rowan County Public Health Department, a provider of health, pregnancy care, and other services.
- Partners Health Management, a coordinator and payer of behavioral health and developmental disabilities services payer of behavioral health and developmental disabilities services.
- Endless Opportunities, a provider of parenting and social support services.

Collectively, the agencies, organizations, and individuals named in this Section A are referred to in this form as the "**SUN Project Partners**." I understand that by authorizing information sharing between and among the SUN Project 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 my treatment and other support services.

B. PURPOSE OF INFORMATION SHARING.

This authorization permits the SUN Project 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.
5. To protect my child's health, safety, and welfare
6. To assess my child's need for—and to provide, manage, and coordinate my child's—medical services.
7. 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.
8. To provide, manage, and coordinate social services and other services for me and my child.
9. To improve service and treatment outcomes for me and my child.
10. To establish and continue financial assistance or other payment for services for me and my child.
11. To assess the quality and effectiveness of SUN Project services.
12. To improve service and treatment outcomes for pregnant women and children who are served by the SUN Team.

C. INFORMATION TO BE SHARED.

I authorize the SUN Project Partners designated above to use, communicate with, and disclose to one another the following information relating to me 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 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.
- 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.
- Housing information, including the stability, affordability, safety conditions, and adequacy of my housing; the identify 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.

- 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.
- Mental health treatment information, 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 Human Services or the Rowan 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.
- 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.
- Developmental disabilities assessments and service information, including service plans and discharge summaries.
- 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 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 Project Partners listed in Section A to share information, then in some instances, these SUN Project Partners may not be able to work together to coordinate services for me and my child.

E. CONFIDENTIALITY.

My healthcare information is protected by a federal health privacy law (the Health Insurance Portability and Accountability Act of 1996 [HIPAA], 45 C.F.R. Pts. 160 & 164). 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 recipient of the information and, therefore, may not prohibit the recipient from redisclosing the information to others.

However, mental health and substance use treatment information has greater protection. I understand that my alcohol and/or drug treatment records are protected by federal law (42 C.F.R. Part 2). I also understand that my mental health, developmental disabilities, and substance use disorder treatment information is protected by state law (G.S. 122C). I understand that if I authorize the disclosure of information protected by these two laws to the SUN Project Partners that these two laws still protect my information, and the SUN Project Partners who receive this information may not redisclose it to anyone else except as permitted or required by these laws or this authorization.

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 not revoked sooner, this authorization expires one year from the date this authorization is signed. (Authorization to disclose information for the purpose of continuing established financial benefits will be considered valid until the cessation of benefits.)

SIGNATURES ON FOLLOWING PAGE

Medical Record #_______________
Edited: 3-2023

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*