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SUN PROJECT

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 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 the following child of mine who is receiving services from the SUN Project.

_____/_____
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, 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 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, 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 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 Project services.

11. 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 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, 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 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.
- 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 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.
- 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.

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- 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 child's 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 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, developmental disabilities, and substance use treatment information has greater protection. I understand that any information relating to my child's substance use disorder treatment services is protected by federal law (42 C.F.R. Part 2). I also understand that any information relating to my child's mental health or developmental disabilities services 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 or mental healthcare 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

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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: _____

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	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*