Medicaid/Other Insurance #_____
Medical Record #_____

SUBSTANCE USE NETWORK (SUN) PROJECT

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

(TO BE SIGNED BY PARENT AFTER BIRTH OF CHILD)

I,_____, date of birth _____ , a client in the SUBSTANCE USE NETWORK (SUN) Project, authorize the agencies and organizations 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 and organizations may work together, as members of the SUBSTANCE USE NETWORK (SUN) Team, 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 date of birth

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) date(s) of birth

Medicaid/Other Insurance #_____
Medical Record #_____

A. WHO MAY SHARE INFORMATION (updated 2-25-2020):

I authorize the following SUN Team members (check all that apply) 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 health, pregnancy care, and other services.

__Cabarrus Partnership for Children (Smart Start Programs), a provider of health and family outreach services.

__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, including Carolinas Medical Center.

__NC Department of Public Safety, Division of Adult Correction and Juvenile Justice.

__Genesis A New Beginning, a provider of mental health and substance abuse services

__McLeod Addictive Disease Center, a provider of outpatient, residential, and medication assisted treatment programs for substance use disorders

__Cardinal Innovations Healthcare, a coordinator and payer of behavioral health and developmental disabilities services.

__Daymark Recovery Services, a provider of outpatient/inpatient behavioral health and psychiatric services for the treatment of mental illness, substance use disorders, and developmental disabilities.

I understand that by authorizing information sharing between and among the SUN Project organizations and agencies designated above, I also am 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:

1. To evaluate my need for healthcare and support 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 services.
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 agencies and organizations designated above to use, communicate with, and disclose to one another the following information relating to my child (the child named on page 1).

- Name, address, date of birth, phone number, and other personal identifying information.
- Healthcare information, including medical history, current medical care and treatment, and the identity of any past and present providers of healthcare.
- Psycho-social history, including family and social history, parentage, social supports, and living environment.
- Housing information, including safety and adequacy of housing, and the identify of other household members and their relationship, if any, to my child.
- 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.
- 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.
- 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 to my child treatment, payment for treatment, enrollment in a health plan, or eligibility for health plan benefits because of my refusal to sign.

E. CONFIDENTIALITY:

Medicaid/Other Insurance #_____
Medical Record #_____

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 and developmental disabilities treatment information has greater protection. I 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 this law, the SUN Project agencies and organizations who receive this information may not redisclose it except as permitted or required by G.S. 122C or this authorization.

F. REVOCATION AND EXPIRATION:

I have the right to revoke this authorization at any time except to the extent that an agency or organization, authorized by this form to make a disclosure, 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 agencies or organizations named and checked above in Section A. In addition, I may revoke this authorization with respect to a provider of healthcare or mental health care services by following the procedures described in that provider's "Notice of Privacy Practices."

If not revoked sooner, this authorization expires automatically upon 30 days after the termination of my, and my child's, involvement in the SUN Project, or one year from the date this authorization is signed, whichever is earlier. (Authorization to disclose information for the purpose of continuing established financial benefits will be considered valid until the cessation of benefits.)

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 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 staff witnessing the signature(s) above. (Please Print)

Medicaid/Other Insurance #_____
Medical Record #_____

_____ _____
Signature of staff witnessing the signature(s) above Date

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

This Authorization to Disclose will be kept on file by the Cabarrus Health Alliance or by another authorized organization on behalf of the SUN team.

Rev.: Date: _____

	ACTION TO REVOKE	

A. WRITTEN REVOCATION (use either 1 or 2 below, not both)

1. I am revoking the entire authorization:

I hereby give notice that the authorization to disclose information relating to _____
Name of legally responsible person

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*

OR

2. I am revoking the authority of the parties named below to disclose and receive information:

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

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

only with respect to the party or parties named below. The authorization remains in effect for other parties named in the authorization.

Authority of_____ to disclose and receive information is revoked.

Authority of_____ to disclose and receive information is revoked.

Authority of_____ to disclose and receive information is revoked.

Authority of_____ to disclose and receive information is revoked.

Medicaid/Other Insurance #_____
Medical Record #_____

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

_____ _____
Signature of Staff witnessing the revocation *Date*

A. VERBAL REVOCATION

I , _____, attest that a verbal declaration was made on
Print name of Staff 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

_____ _____
Signature of Staff receiving revocation *Date*