Medicaid/Other Insurance #_____
Medical Record #_____

SUBSTANCE USE NETWORK (SUN) PROJECT OF NORTH CAROLINA

CLIENT AUTHORIZATION TO USE AND DISCLOSE PREGNANT WOMAN'S HEALTHCARE, SUBSTANCE USE DISORDER TREATMENT, AND OTHER INFORMATION

I,_____, date of birth _____ , a client of 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 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 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, a provider of health, early education, 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 under the Charlotte-Mecklenburg Hospital Authority.

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

__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.

__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.

Medicaid/Other Insurance #_____
Medical Record #_____

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 my care and treatment by sharing and using information:

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 members designated above to use, communicate with, and disclose to one another the following information relating to me.

- 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 health, 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 Public Safety, Division of Adult Correction and Juvenile Justice, 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 also 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.

E. CONFIDENTIALITY:

My healthcare information is protected by a federal health privacy law (the Health Insurance Portability and Accountability Act [HIPAA] of 1996, 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 that these two laws still protect my information, and the SUN Team members who receive this information may not redisclose it to anyone else except as permitted or required by these laws or this authorization.

Medicaid/Other Insurance #_____
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F. REVOCATION AND EXPIRATION:

I have the right to revoke this authorization at any time except to the extent that an organization or agency, 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 agencies or organizations 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 automatically upon 30 days after the termination of my 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 Client (Please Print)

_____ _____
Signature of Client (18 and over or Emancipated Minor) Date

And, if the client is an unemancipated minor or incompetent adult:

_____
Name of Parent, Guardian or other Legally Responsible Person (Please Print)

_____ _____
Signature of Parent, Guardian, or other Legally Responsible Person 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.

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

_____ _____
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: _____

Medicaid/Other Insurance #_____
Medical Record #_____

	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 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*

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 client

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.

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

_____ _____
Signature of Staff witnessing the revocation *Date*

Medicaid/Other Insurance #_____
Medical Record #_____

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 client

_____ _____
Signature of Staff receiving revocation *Date*