NCHIIN North Coast Health Improvement and Information Network

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

Perinatal Substance Use Disorder Project (aka "The Humboldt RISE" project).

The North Coast Health Improvement and Information Network (NCHIIN) is a community health improvement and health information exchange organization in Humboldt County, CA. NCHIIN is a resource and information hub that allows your health information to be shared by participating medical groups, hospitals, and other health and social care providers through secure, electronic means. NCHIIN coordinates with its trusted network of providers to coordinate services and resources to members of the community through programs such as the Perinatal Substance Use Disorder Project (aka "The Humboldt RISE Project"). The Notice of Privacy Practices posted at www.nchiin.org/perinatalsudproject explains how NCHIIN uses and protects your information.

Completion of this document authorizes the disclosure, sharing, and use of substance use disorder information about you. Signing this authorization is voluntary –your refusal to sign this form will not adversely affect your ability to receive services from providers directly. By signing this form, you agree to allow NCHIIN and its network of providers to share your health information, records, and other data with each other.

I hereby acknowledge and agree as follows:

- My health care providers may share my information with NCHIIN and all other providers that participate in NCHIIN that are involved in my care. This may include:
    - My name, address, data of birth, and other basic information about me;
    - My background and medical history;
    - My mental or physical conditions;
    - Treatment and services I have received; and
    - Housing or other social services I may need.

- My health information will be used to:
    - Determine my eligibility for and enroll me in programs, such as the Perinatal Substance Use Disorder Program;
    - Coordinate my care;

- Receive payment for services provided to me; and
- Improve the quality of services and conduct program work.

I specifically authorize my treating providers to share the following information (*check as appropriate*):

☐ Mental health diagnosis, assessment, and treatment information _____ (*initial*)
☐ HIV/AIDS test results, diagnosis, care, and treatment information ____ (*initial*)

I specifically authorize my past, present, and future treating providers to release my substance use disorder records (SUD), as specified below:

- Substance use test results
- SUD diagnosis
- Treatment plan
- Payment/billing information
- SUD program attendance
- Progress notes
- Any medical or mental health records included in my SUD records
- Other: _____

My SUD information will be available among and between NCHIIN and its network of providers. The network of providers participating in the project are listed in the Notice of Privacy Practices and may change from time to time.

I understand:

- I may refuse to sign this authorization. My refusal could affect my ability to obtain services under this specific program, but will not adversely affect my ability to get services from providers directly.
- I may obtain a copy of this authorization or the health information that I am being asked to allow the use or disclosure of.
- I have the right to cancel this authorization at any time by sending written notice to NCHIIN at 2662 Harris Street, Eureka, CA 95503 or fax to 707-443-2527. The cancellation will only apply to information covered by this authorization and information shared after I notify you of the cancellation.
- My eligibility for Medi-Cal or ability to receive treatment by health care providers does not depend on whether I sign this authorization.
- Information shared under this authorization may be re-shared with others and may no longer be protected by state and federal confidentiality laws. SUD information may not be re-disclosed unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

- Unless revoked earlier, this Authorization will expire in three (3) years, or on the following date: _____

If you agree, sign your name below:

Client Signature: _____ Date: _____

If signed by a person other than the client, please write that person's relationship to the client:

Relationship to Client: _____

Personal Representative's Name: _____
Date:_____

Agency Name:_____

Program Representative Name:_____