# Instructions: Using the Sample Client Authorization to Disclose Confidential Information

## Purpose of the Sample Authorization

The Sample Client Authorization to Disclose Confidential Information (the "Sample Authorization") provides guidance to adult protection multidisciplinary teams ("MDTs") who seek to create a form (sometimes called a "release of information" or "consent form") that will enable a vulnerable adult who is being served by the MDT to authorize MDT members to share confidential information about the adult's case with each other.

## Instructions for Use

Members of an adult protection MDT (or individuals interested in forming an adult protection MDT) should modify the terms of the Sample Authorization to meet the specific needs of their MDT and their community. For purposes of the Sample Authorization and these instructions for its use, a vulnerable adult who is served by the MDT is referred to as the "client" of the MDT.

### 1. Consult with Legal Counsel and Understand Legal Requirements

MDT members should consult with legal counsel prior to using this Sample Authorization or a modified version of it. Many confidentiality laws—including federal and state laws governing the confidentiality of health information, mental health information, substance use disorder treatment information, and social services information—have specific requirements for a client to authorize the disclosure of their confidential information. For example, these laws specify particular elements that such an authorization form should contain. Some of these laws also have requirements about specific notices that must be provided when information is released pursuant to client consent, requirements to document disclosures made with client consent, and requirements regarding retaining a copy of the signed consent form. These laws also have provisions regarding which other individuals may be able to sign an authorization on behalf of a client (e.g., the client's guardian). ***An MDT seeking to use or modify the Sample Authorization needs to understand which confidentiality laws (if any) apply to its members, and confirm that the form meets the requirements of each of those laws.***

**As modified, an MDT's authorization form should:**

- describe, in a specific and meaningful fashion, what types of information about the vulnerable adult may be disclosed;
- list, in a specific and meaningful fashion, the purposes for which the client's information may be disclosed;
- list all parties to whom the client's information may be disclosed (i.e., all MDT members);

- list all parties that are being given permission to disclose the client's confidential information to each other (i.e., all MDT members);
- include a statement about the ability or inability of MDT members to condition treatment, payment, enrollment, or benefits eligibility based on whether the individual signs the authorization form (conditioning treatment, payment, enrollment, or benefits eligibility on execution of an authorization is generally prohibited by HIPAA);
- include any notices to the client that are required to be included on such a form by any confidentiality laws that apply to any MDT member;
- include a specific date or event upon which the authorization will expire, which can be an actual date (e.g., "January 1, 2026") or an event that triggers the expiration of the authorization form (e.g., "when Client is no longer receiving services from any member of the Smart County Multidisciplinary Team"); and
- include a section that explains the process for revoking the authorization and describes any exceptions to the client's right to revoke the authorization.

## 2. Ensure Form is Only Signed by Individuals with Decision-making Capacity

MDTs should only use a form like the Sample Authorization with a client who has mental capacity to make the decision to sign the form, unless all of the confidentiality laws applicable to individual MDT members allow a guardian or other personal representative to sign on the client's behalf. There are several foundational requirements that must be met to obtain valid consent from a client to disclose their confidential information.

- The client must have the capacity to consent to the disclosure. There is very little guidance in federal and state confidentiality laws on how to determine whether an individual has mental capacity to sign a release of confidential information. Generally speaking, an individual should have the appropriate capacity to 1) understand the nature and extent of the confidential information at issue, 2) realize the effects of signing the form (including potential risks and benefits), and 3) communicate their choice to sign (or not sign) the form. In some cases, mental or physical illness, intellectual or developmental disability, dementia, or active substance use may cause an individual to lack cognitive capacity to consent to the release of confidential information. If a client lacks cognitive capacity to consent to the disclosure, the client should not be presented with, or asked to sign, an authorization form that impacts their legal rights.

- The client's decision to consent must be informed by accurate information that allows the client to weigh the risks and benefits of the decision. The client must be informed of the nature of the document they are signing, including the type of information that may be disclosed, the parties to whom it may be disclosed, the purposes for which it may be disclosed, and the extent of any limits on redisclosure. These terms should be reflected in the text of the authorization form itself. As a best practice, this information should also be described verbally to the client before they sign the form, to ensure that the client understands their decision to sign the form and answer any questions the client may have.

- The client's decision to give consent must be voluntary.  A client should never be pressured, coerced, or forced into signing a document to release their confidential information. Unlawful coercion and undue influence over a client's decision may take many forms, including someone exerting physical, emotional, social, or financial pressure on the client to sign. Additionally, some confidentiality laws prohibit agencies and organizations from conditioning a client's receipt of services or benefits on signing a release of their confidential information. MDT members must be careful to ensure that a client is making the decision that she thinks is right for herself—not the decision that the agency or organization thinks is best for her, or that her family or friends think is best for her. Even if they are well-intentioned, agencies, organizations, family members, and caregivers must avoid using subtle forms of manipulation, encouragement, and pressure that would push a client towards signing an authorization to disclose their confidential information. After the client is presented with the information needed to make a decision about signing the authorization form, the client must make the decision to sign it willingly and independently.

## 3. Understand Who Can Sign the Form

As described above, a client with cognitive capacity to make decisions about their own confidential information can sign a form like the Sample Authorization on their own behalf. Some confidentiality laws also allow a "personal representative" to sign an authorization on behalf of a client who lacks cognitive capacity.  For example, if another person has legal authority under applicable state or federal law to make health care related decisions for an adult client, then HIPAA allows that person to sign an authorization for the disclosure of the client's protected health information, so long as the personal representative's authority to act on behalf of the client is documented on the authorization form. Likewise, state social services rules allow an individual  "acting on behalf of the client in accordance with their right to act on the client's behalf under a legal order, federal or State law" to sign an authorization to release the client's confidential information.

When modifying the Sample Authorization or creating a form like it, MDTs should consult with legal counsel about the confidentiality laws that apply to their members and whether those laws allow a guardian of the person, general guardian, health care agent named in a health care power of attorney, or other individual to sign on behalf of a client who lacks cognitive capacity to sign the form. The signature page of the form should be modified accordingly to reflect the requirements of those laws. If a personal representative wishes to sign on behalf of a client, an MDT should also consider asking for some type of documentation of the individual's legal authority to act on behalf of the client (i.e. proof that the individual has the legal authority they claim to have).

## 4. Carefully Implement and Use the Form

Any agency or organization relying upon a written authorization to disclose an individual's confidential information should retain and store a copy of the signed authorization. A copy of the signed authorization should also be given to the client.

When an agency or organization obtains or receives a written authorization for the disclosure of confidential information, it must make sure that any disclosures of information it makes are consistent with the authorization. Unless otherwise permitted or required by law, an MDT member cannot go beyond the scope of the authorization with respect to how much information they disclose to other MDT members, what type of information they disclose, the purposes for which the information may be disclosed, or the parties to whom information may be disclosed. The terms of the authorization control how much information an agency or organization participating in the MDT can release, for what purposes, and to whom.

Note that as drafted, the Sample Authorization only authorizes disclosures of information to or from the MDT members who are listed on the form at the time when the client signs it. If a new organization or agency begins participating in the MDT after the client has already signed the form, the Sample Authorization would not allow the disclosure of the client's confidential information to that new member agency or organization. In such a case, the form would have to be revised to include the new agency or organization and the client would need to sign the revised form.

# [MDT NAME]

## CLIENT AUTHORIZATION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

By signing this document, I hereby 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 services for me as part of the [Smart County Adult Protection Multidisciplinary Team ("Smart County MDT")].

### 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, for the purposes identified in Section B of this form:

- [AGENCY/ORGANIZATION NAME, a [DESCRIBE TYPE OF AGENCY/ORGANIZATION], which [DESCRIBE CATEGORY OF SERVICES PROVIDED BY AGENCY/ORGANIZATION].
  – [Example: Smart County Department of Social Services, a provider of adult protective services and other services for vulnerable adults.]
  – [Example: Smart County Health Department, a provider of public health services.]
- [FOR INDIVIDUALS IN MDT WHO ARE NOT REPRESENTING AN AGENCY OR ORGANIZATION IN THE MEETING: INDIVIDUAL NAME, a [DESCRIBE PROFESSION OR ROLE] serving on the Smart County MDT]
  – [Example: Jane Smith, a victim advocate serving on the Smart County MDT]

Collectively, the agencies, organizations, and individuals named in this Section A are referred to in this form as the "MDT Members." I understand that by authorizing information sharing between and among the MDT Members 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 services on my behalf.

### B. PURPOSE OF INFORMATION SHARING.

This authorization permits the MDT Members to take a coordinated, multidisciplinary approach to helping me, by sharing and using information for case management, care coordination, and for the following purposes:

[LIST PURPOSES FOR WHICH MDT MEMBERS ARE AUTHORIZED TO DISCLOSE THE CLIENT'S INFORMATION TO EACH OTHER. SOME EXAMPLES, WHICH CAN BE MODIFIED OR DELETED, ARE PROVIDED BELOW.]

1. To assess my need for appropriate social services, healthcare services, mental health treatment services, legal services, housing services, and other community support services.
2. To ensure that I am provided with appropriate social services, healthcare services, mental health treatment services, legal services, housing services, and other community support services, and to coordinate the provision of such services for me.
3. To assist in the investigation of a potential crime of abuse, neglect, or exploitation against me.
4. To assist in the evaluation of a report of abuse, neglect, or exploitation by a local department of social services.
5. To protect my health, safety, and welfare.

## C. INFORMATION TO BE SHARED.

I authorize the MDT Members 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 my medical care and treatment.
- 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.
- History of involvement, if any, with county departments of social services, including the findings of any adult protective services evaluations.
- Housing information, including the stability, affordability, safety conditions, and adequacy of my housing.
- 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.
- Intellectual and 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, tuberculosis, and any other reportable communicable disease listed in 10A NCAC 41A.0101.
- 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 any treatment, services, programs, or benefits offered by any MDT Members, and refusing to sign this form will not affect my application or participation in any treatment, services, or programs offered by any MDT Members.

I understand that if I do not sign this form permitting the MDT Members listed in Section A to share information, then in some instances, these MDT Members may not be able to share certain information with each other to coordinate services for me.

## E. CONFIDENTIALITY.

My healthcare information is protected by a federal law, the Health Insurance Portability and Accountability Act of 1996, otherwise known as "HIPAA" (45 C.F.R. Parts 160 & 164). I understand that once my health care information 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, some of my mental health and substance use treatment information has greater protection. I understand that my alcohol and/or drug treatment records and information 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 records and information are protected by state law (G.S. 122C). I understand that if I authorize the disclosure of information protected by these two laws to the MDT Members that these two laws still protect my information, and the MDT Members 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 an MDT Member, authorized by this form to disclose information, has already taken action in reliance on it. I may revoke this authorization by signing the ACTION TO REVOKE section of this form and submitting it to one of the MDT Members named 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 I do not revoke this authorization sooner, this authorization expires upon the following date or event:

_______________________________________________ (client must identify a date or event).

**SIGNATURES ON FOLLOWING PAGE**

## 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 is an adult who has been adjudicated incompetent by a court, authorization to disclose must be given by the client's guardian of the person, general guardian, or other person with authority under applicable law to act on behalf of the client in making decisions related to health care.

_______________________________________________
*Name of Guardian or other Legally Responsible Person for the Client (Please Print)*

_______________________________________________ ____________________
*Signature of Guardian 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 guardian of the person or general guardian with the authority to make health care decisions for the client.

___ I am the client's health care agent named in a health care power of attorney with the authority to make health care decisions for the client.

## WITNESS

_______________________________________________
***Name and title of MDT Member or staff of MDT Member witnessing the signature above.***

_______________________________________________ ____________________
***Signature of MDT Member of staff of MDT Member witnessing the signature above.*** ***Date***

**The individual(s) signing this authorization must be given a copy of the signed authorization.**

## ACTION TO REVOKE

**Use either A or B below.**

### A. WRITTEN REVOCATION

The authorization to disclose information relating to ______________________________________
*Name of MDT client*

signed by __________________________ on ___________ is revoked, effective ______________.
*Name of person who signed authorization* *Date of authorization* *Date of revocation*

________________________________________________________ ______________________
***Signature of person who is revoking authorization*** ***Date***

### B. VERBAL REVOCATION

I, ___________________________________________________, attest that a verbal declaration
*Print name of MDT Member or staff of MDT Member receiving revocation*

was made on ___________________ by ______________________________________________to
*Date of verbal revocation* *Print name of client or legally responsible person*

revoke this authorization to disclose information relating to________________________________.
*Print name of client*

________________________________________________________ ____________________
***Signature of MDT Member or staff of MDT Member receiving revocation*** ***Date***