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Creating Release of Information Forms for Use by Multidisciplinary Teams

Disclosure of Health, Mental Health, Social Services, and Substance Use Disorder Information with Client Consent

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Introduction

The formation of multidisciplinary teams (MDTs)—groups of professionals from different disciplines working together to achieve a common goal—can be an effective way to serve individuals with complex needs. For example, there are currently MDTs in North Carolina that exist to coordinate care for pregnant individuals with substance use disorders, MDTs that focus on protecting vulnerable adults from abuse and neglect, and MDTs that coordinate responses to cases of child abuse, neglect, and dependency. An MDT may include professionals from many different fields who are subject to a wide variety of state and federal confidentiality laws, all working together to coordinate services for a single individual or case. For example, some MDTs may include healthcare providers, social workers, mental health professionals, law enforcement officers, and attorneys, among other community partners. Restrictions on information sharing imposed by confidentiality laws may create significant barriers to effective coordination and responsiveness within an MDT. However, in some cases, there is a legal pathway for MDT members to share confidential information with each other—through the consent of the client or patient served by the MDT.

Many of the confidentiality laws that apply to North Carolina's social services agencies, mental health facilities, healthcare providers, local health departments, and substance use disorder treatment providers permit disclosure of confidential information with client or patient consent. However, these confidentiality laws and regulations were written at different times by different legislative bodies or government agencies to address different sets of information. The various laws often do not "speak to" each other, meaning they use different terms, create different restrictions, provide different exceptions to those restrictions, and apply to different types of information or different entities. These differences make it challenging to draft a single form by which a client may authorize multiple agencies or organizations within an MDT to share confidential information about that client with each other.

This bulletin aims to help attorneys and other professionals weave together the requirements for individual consent across many confidentiality laws so that they can draft legally compliant release of information (ROI) forms. In cases where MDTs can obtain informed and voluntary consent, a multiparty ROI form may serve as a powerful tool for sharing confidential information across different organizations and agencies working together to serve a common goal. For example, information sharing can help organizations coordinate services and treatment for clients and patients, identify gaps in services, protect clients and others in the community, and build capacity to serve more individuals.

For purposes of consistency, this bulletin will generally use the term "client" to refer to an individual receiving services, case management, case review, or other coordination of care or support from an MDT. Some organizations and agencies involved in an MDT may use the word "patient" or "victim" to refer to this individual, depending on the context. Additionally, although the confidentiality laws discussed herein use a variety of terms to describe a client's consent to disclose information, this bulletin uses the phrase "ROI form" to refer to the document that is used to memorialize a client's consent to the release of their protected information.

Road Map for Using This Bulletin

This bulletin is divided into four parts, each of which is briefly described below.

1. **Foundational Principles of Obtaining Client Consent.** Part 1 begins with a description of how an MDT must obtain consent to release confidential information. Before an MDT can use an ROI form, it must determine that a client (or the client's legal representative, if allowed by applicable law) has the capacity to give informed, voluntary consent.
2. **Requirements for Client Consent to Release Information Under Federal and State Confidentiality Laws.** Part 2 discusses the requirements for obtaining client consent to disclose confidential information under the following confidentiality laws:
    - the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA);
    - North Carolina's communicable disease confidentiality statute (Chapter 130A, Section 143 of the North Carolina General Statutes (hereinafter G.S.));
    - the federal law governing the confidentiality of substance use disorder (SUD) patient records (42 C.F.R. Part 2) ("the federal SUD confidentiality law" or "42 C.F.R. Part 2");
    - North Carolina's mental health, developmental disabilities, and substance abuse (MH/DD/SA) confidentiality law (G.S. 122C-52 through -56.1) ("the state MH/DD/SA confidentiality law" or "G.S. 122C"); and
    - North Carolina's social services confidentiality law (G.S. 108A-80).
3. **Weaving Together Legal Requirements for Multiparty Release of Information Forms.** Part 3 identifies common requirements for ROI forms across all the confidentiality laws discussed in Part 2, while also highlighting some requirements that are unique to particular laws.
4. **Best Practices for Using Multiparty Release of Information Forms in the Multidisciplinary Team Context.** Part 4 discusses best practices for using multiparty ROI forms, including collectively developing such a form, agreeing on how the form will be used, understanding requirements for storage of signed forms, tracking expiration dates or revocations, updating the form as needed, and training MDT members on how the form should be used.

Readers who are not attorneys and who are interested in creating or implementing multiparty ROI forms will find information about legal requirements and best practices in this bulletin but should consult an attorney as part of the process of developing their own forms.

Part 1. Foundational Principles of Obtaining Client Consent

Each confidentiality law that allows disclosure of protected information with client consent has different requirements for the form that consent must take and the information that must be presented to the client. These requirements are described in more detail in Part 2 of this bulletin. Regardless of the relevant laws at issue, however, there are several foundational requirements that must be met to obtain valid consent from a client to disclose their confidential information.

1. **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 the mental capacity to sign a release of confidential information.[1] Generally speaking, an individual must have the appropriate capacity to (1) understand the nature and extent of the confidential information at issue, (2) realize the effects of signing the ROI form (including potential risks or benefits), and (3) communicate their choice to sign (or not sign) the ROI form.[2] Providers must use their professional judgment when determining whether a client has the capacity to consent to a disclosure of confidential information. 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 decide about signing an ROI form. If a client lacks cognitive capacity to consent to the disclosure, the client should not be presented with, or asked to sign, an ROI form that impacts their legal rights.

   Some confidentiality laws allow other individuals to sign an ROI form 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 healthcare-related decisions for an adult client (such as a healthcare agent named in a healthcare power of attorney), then HIPAA allows that person to sign an authorization for the disclosure of the client's protected health information, so long as that person's authority to act on behalf of the client is documented on the authorization to disclose the client's protected information.[3] When discussing specific confidentiality laws, this bulletin will address the extent to which those laws allow a different individual to sign an ROI on the client's behalf.
2. **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 should 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

1. For an overview of legal issues associated with decision-making by clients with diminished capacity in the context of other types of legal documents, see A. Frank Johns, *Older Clients with Diminishing Capacity and Their Advance Directives*, 39 Real Prop. Prob. & Tr. J. 107 (2004).

2. These elements are drawn from literature on informed consent and decisional capacity for scientific research and medical treatment. See, e.g., Johan Bester, Cristie M. Cole, and Eric Kodish, *The Limits of Informed Consent for an Overwhelmed Patient: Clinicians' Role in Protecting Patients and Preventing Overwhelm*, 18 AMA J. Ethics 869, 872 (2016), https://doi.org/10.1001/journalofethics.2016.18.9.peer2-1609. ("A valid process of informed consent requires four things: voluntariness (the decision is free from coercion or undue influences), disclosure (the clinician's sharing of information relevant to the patient's decision), understanding (appreciating the risks, benefits, and nature of the procedure), and capacity (the ability to engage in reasoned deliberation, comparing the risks and benefits of the procedure with personal life goals)"); Michelle Biros, *Capacity, Vulnerability, and Informed Consent for Research*, 46 J. L., Med. & Ethics 72 (Mar. 2018), https://doi.org/10.1177/1073110518766021.

3. *See* 45 C.F.R. § 164.508(c)(1)(vi).

purposes for which it may be disclosed, and the extent of any limits (including time limits) on redisclosure.[4] The client should also be informed of their ability to revoke their authorization to disclose their confidential information. Most confidentiality laws also have specific categories of information that must be included in an ROI form, some of which are described later in this bulletin. At a minimum, these required elements should be reflected in the text of the ROI form presented to the client. As a best practice, this information should also be described verbally to the client before they sign the ROI form, to ensure that the client understands their decision to sign the form and answer any questions the client may have. Some confidentiality laws require an ROI form to be written in plain language.[5] Nonetheless, it may still be difficult for some clients to understand the terminology in the document without a verbal explanation.

3. **The client's decision to give consent must be voluntary.** An individual should never be pressured, coerced, or forced into signing a document to release their confidential information. Unlawful coercion and undue influence over an individual'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 an ROI form.[6] Agencies and organizations 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 should avoid using subtle forms of manipulation or coercion that would pressure an individual to sign an ROI form. Similarly, agencies and organizations should not seek a court order requiring the client to sign an ROI, since such an order would *compel* the client to sign, rather than allowing the client to make a truly voluntary decision.[7]

   After being presented with the information needed to make a decision about the release, an individual must make the decision to sign willingly and independently. A truly informed and voluntary consent process gives the individual client agency when exercising their right to disclose their own information and determining the extent and nature of a particular disclosure of that information.

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4. These recommendations for informing clients are drawn from principles reflected in 45 C.F.R. § 46.116 (which governs informed consent for human subjects of research), as well as requirements from various laws and regulations discussed later in this bulletin (e.g., 45 C.F.R. § 164.508(c); 42 C.F.R. § 2.31; Title 10A, Chapter 26B, Section .0205 of the North Carolina Administrative Code (hereinafter N.C.A.C.); 10A N.C.A.C. 69, § .0401(g)).

5. For example, HIPAA requires that authorizations be written in plain language. 45 C.F.R. § 164.508(c)(3).

6. *See, e.g.*, 45 C.F.R. § 164.508(b)(4), (c)(2)(ii); 42 C.F.R. § 2.31(b)(3); 10A N.C.A.C. 26B, § .0205.

7. When working with clients, agencies and organizations may need to seek court orders compelling the disclosure of confidential information or records. These orders should be directed at the organization or agency that has custody or control of the records or information (requiring their disclosure), rather than directing the client to sign an ROI.

Part 2. Requirements for Client Consent to Release Information Under Federal and State Confidentiality Laws

This section discusses the requirements for individual consent to disclose confidential information under HIPAA (protected health information), G.S. 130A-143 (communicable disease information), 42 C.F.R. Part 2 (substance use disorder diagnosis and treatment information), G.S. 122C-52 through -56.1 (mental health, developmental disabilities, and substance abuse services information), and G.S. 108A-80 (social services information). These laws have different requirements for ROI forms, including the contents of such forms, which will be discussed separately for each of these laws. Some MDTs may also have members who are subject to other confidentiality laws that are beyond the scope of this bulletin, such as the Family Educational Rights and Privacy Act (FERPA).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Which Agencies and Organizations Are Subject to HIPAA?

Among other things, HIPAA and its implementing regulations[8] govern the use and disclosure of "protected health information" (PHI) by "covered entities" and their "business associates." There are three types of covered entities: health plans (e.g., insurance companies), healthcare clearinghouses (e.g., companies that process certain health data), and healthcare providers who electronically transmit health information as part of a transaction that is regulated under HIPAA (e.g., a healthcare provider who submits a patient's health information electronically as part of billing the patient's insurance). A business associate is an individual or organization that uses PHI to carry out certain HIPAA-covered functions on behalf of a HIPAA covered entity or to perform certain tasks for a covered entity pursuant to a business associate agreement.[9]

In addition to addressing confidentiality, HIPAA establishes administrative requirements for covered entities and business associates that are intended to facilitate and support the protection of confidential information, such as the requirements to designate a Privacy Officer, implement data security standards, develop certain organizational policies and procedures, and ensure that all workforce members receive HIPAA training.[10]

What Information Does HIPAA Protect?

HIPAA governs the use and disclosure of PHI, which is a subset of individually identifiable health information (IIHI).[11] IIHI is information that is created, received, or maintained by a covered entity that identifies an individual or for which there is a reasonable basis to believe the information could be used to identify an individual, and that relates to any of the following:

- an individual's past, present, or future physical or mental health status or condition;
- the provision of healthcare to an individual; or
- the past, present, or future payment for the provision of healthcare to an individual.

8. HIPAA's implementing regulations, found at 45 C.F.R. §§ 160, 162, and 164, are often colloquially referred to as "HIPAA." For the purposes of this bulletin, "HIPAA" refers to the 1996 law and its implementing regulations, collectively.

9. See 45 C.F.R. § 160.103 for full definitions of "covered entity," "health plan," "health care clearinghouse," "health care provider," and "business associate."

10. *See* 45 C.F.R. pts. 160, 162.

11. See 45 C.F.R. § 160.103 for the definition of "individually identifiable health information" and "protected health information."

PHI is IIHI that is transmitted or maintained in any form (electronically, on paper, or orally) but specifically excludes information that

- is protected under the Family Educational Rights and Privacy Act (FERPA),
- is maintained in employment records held by the covered entity in its role as an employer, or
- pertains to a person who has been deceased for more than fifty years.[12]

HIPAA recognizes two methods that a covered entity may rely upon to determine that information is *not* individually identifiable (and therefore not IIHI or PHI). The first method is known as the "Expert Determination Method," which requires that someone with expertise in statistics, science, and deidentification methods analyze the information, make a determination that there is only a very small risk that the information could be used (alone or in combination with other reasonably available information) to identify an individual, and then document that determination.[13] In practice, few covered entities regularly employ the Expert Determination Method, in part because it can be costly to employ the services of someone with the requisite expertise to perform these analyses. Instead, covered entities often rely on the second method of deidentification described under HIPAA, known as the "Safe Harbor Deidentification Standard."[14] Under this standard, information is considered individually identifiable if it contains *any* of the following pieces of data related to the client or the client's relatives, household members, or employer:[15]

- name;
- geographic data for areas smaller than the state (e.g., street addresses or counties);
- telephone and fax numbers;
- email addresses;
- social security, medical record, health plan beneficiary, account, certificate/license, vehicle identifier/license plate, device identifier, and serial numbers;
- web and Internet Protocol (IP) addresses;
- biometric identifiers (e.g., fingerprint or voiceprint);
- full-face photographic images and any comparable images (e.g., photos or videos that identify an individual); or
- any other unique identifying number, characteristic, or code that could re-identify the individual.

12. *Id.*

13. 45 C.F.R. § 164.514(b)(1).

14. For additional information about methods for deidentification of health information under HIPAA, please see U.S. Dep't of Health & Hum. Servs. (HHS), Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html.

15. 45 C.F.R. § 164.514(b)(2).

Can Information Protected by HIPAA Be Disclosed with Client Consent?

Yes. Unless the disclosure is specifically permitted or required under HIPAA, a covered entity may not disclose an individual's PHI without first obtaining a valid ROI form from the individual.[16]

There are some disclosures of PHI that are specifically required or permitted under HIPAA and thus do not require the client's prior permission.[17] For example, HIPAA allows a covered healthcare provider to share a client's PHI with another healthcare provider (regardless of whether the second provider is subject to HIPAA) for the purpose of facilitating the client's "treatment," as that term is defined at 45 C.F.R. § 164.501. However, in many situations, not all partners in an MDT will be HIPAA covered entities or healthcare providers in a treatment relationship with the client. In these instances, obtaining an ROI form to disclose the client's PHI will likely be the easiest pathway for sharing information among MDT partners.

What Are the Requirements Under HIPAA for a Valid ROI Form?

HIPAA's requirements for a valid written ROI form are set out at 45 C.F.R. § 164.508(b)–(c) and include requirements related to the content of the ROI form, invalid and defective ROI forms, compound ROI forms, and documentation and retention of ROI forms.

Contents of an ROI Form

A valid ROI form must be written in plain language and contain the following elements:[18]

- *A description of the PHI that may be disclosed pursuant to the ROI form.* The description must identify the PHI "in a specific and meaningful fashion."[19]
- *The name of the person(s), or class of persons, that is being given permission to release the client's PHI.* The parties authorized to disclose information may be described in the ROI form as a class, rather than named individually. The United States Department of Health and Human Services (HHS), which enforces HIPAA through its Office for Civil Rights, has explained in guidance that the following example of a description of a class

16. 45 C.F.R. § 164.508(a)(1). In addition to a client's authorization to disclose PHI, HIPAA provides a second pathway through which a client or their personal representative may instruct a covered entity to disclose the client's PHI to the client, their personal representative, or a third party. This pathway is set out at 45 C.F.R. § 164.524, known as the Right of Access provision. There are key differences between the use of an authorization and a client's exercise of the Right of Access to disclose PHI. For example, a covered entity *may* disclose PHI in response to a client's authorization, but generally *must* disclose PHI in response to a request made under the Right of Access provision. MDTs will likely find that authorizations are an administratively easier approach to facilitating ongoing information sharing between MDT partners than prompting clients to initiate requests for disclosure of PHI under the Right of Access provision. Nevertheless, MDT partners that are covered entities should familiarize themselves with the requirements for responding to requests for disclosure of PHI under the Right of Access provision. For additional information about the Right of Access provision, see Kirsten Leloudis, *HIPAA and the Right of Access: A Q&A for Covered Entities Categories*, Coates' Canons: NC Loc. Gov't L. (blog) (Feb. 9, 2023), https://canons.sog.unc.edu/2023/02/hipaa-and-the-right-of-access-a-qa-for-covered-entities/.

17. *See* 45 C.F.R. § 164, subpt. E for more information about permitted uses and disclosures of PHI.

18. The list of core elements and required statements for an authorization under HIPAA may be found at 45 C.F.R. § 164.508(c). This bulletin will continue to use the term "ROI form," but HIPAA uses the term "authorization" when describing each of these requirements.

19. 45 C.F.R. § 164.508(c)(1)(i).

of persons is sufficient: "[A]ny health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf."[20]

- *The name of the person(s), or class of persons, to whom the covered entity may disclose the PHI.* One ROI form may be used to memorialize the client's agreement for the covered entity to release the client's PHI to multiple different parties.[21] The parties authorized to receive information may be described in the ROI form as a class, rather than named individually. HHS has explained in guidance that the following example of a description of a class of persons is sufficient: "[T]he employees of XYZ division of ABC insurance company."[22]
- *A description of the purpose for the disclosure of the PHI.*
- *An expiration date or event.* This can be a specific date (e.g., "December 1, 2030") or an event that triggers the expiration of the ROI form (e.g., "when Patient XYZ ceases to be a patient of and is no longer receiving services from any member of the ABC multidisciplinary team").
- *Individual's signature and date of signature.* As described later in this bulletin, HIPAA allows an individual's "personal representative" to sign an ROI form on the individual's behalf. If the ROI form is signed by the individual's personal representative, it must also include a description of the personal representative's authority to sign on the individual's behalf. This includes situations where a parent is signing an ROI form on behalf of a minor child, in which case the description of authority could be as simple as "Parent of Patient XYZ." HIPAA does not require that the signature on an ROI form be notarized or witnessed.[23]
- *A statement about the individual's right to revoke the ROI form in writing.* The statement must explain the process for revoking the ROI form in writing and describe any exceptions to the client's right to revoke the ROI form.[24] If the client must send an email or letter to revoke the ROI form, the email address or mailing address that the revocation must be sent to should be included in the ROI form.
- *A statement about the covered entity's ability or inability to condition treatment, payment, enrollment, or benefits eligibility based on whether the individual signs the ROI form.* For example, such a statement might read: "If you choose not to sign this form, you 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 your refusal to sign." Conditioning

20. *See* HHS, *May a Valid Authorization List Categories of Persons Who May Use or Disclose Protected Health Information, Without Naming Specific Individuals or Entities?*, HIPAA FAQs for Professionals (FAQ 473), https://perma.cc/3E4M-8WUY (Sept. 24, 2003).

21. 45 C.F.R. § 164.508(c)(1)(ii).

22. HHS, *May a Valid Authorization List Categories of Persons Who May Use or Disclose Protected Health Information?*

23. HHS, *Does the Privacy Rule Require That an Authorization Be Notarized or Include a Witness Signature?*, HIPAA FAQs for Professionals (FAQ 478), https://perma.cc/256Q-JE3M (Sept. 24, 2003).

24. If the process for revoking an authorization is included in the covered entity's Notice of Privacy Practices, the covered entity may list a reference to the Notice of Privacy Practices rather than repeating the statement in the authorization form. 45 C.F.R. § 164.508(c)(2)(i)(B).

treatment, payment, enrollment, or benefits eligibility on execution of an ROI form is generally prohibited by HIPAA, except in the limited situations described at 45 C.F.R. § 164.508(b)(4).
- *A statement about the potential for redisclosure of the individual's PHI.* The statement must put the individual on notice that once the PHI is disclosed in accordance with the ROI form, it may no longer be protected by HIPAA if the recipient is not a covered entity or business associate and could be redisclosed by the recipient in accordance with any other applicable law.
- *A statement about remuneration to the covered entity, as applicable.* If the ROI form will permit the HIPAA covered entity to sell the individual's PHI or receive payment for using the individual's PHI for marketing, then the ROI form must include a statement about the remuneration to the covered entity.[25]

An ROI form can include other elements in addition to those listed above as long as they are not inconsistent with HIPAA's required elements.[26]

Defective and Invalid ROI Forms

Under HIPAA, an ROI form that has not been filled out completely—that is, if information has not been provided for each of the required elements described above—is defective and invalid. An ROI form will also be considered invalid under HIPAA if

- the expiration date has passed or the covered entity knows that the expiration event has occurred;
- the covered entity knows that the ROI form has been revoked by the client;
- the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits was conditioned on the individual signing the ROI form (except as allowed under 45 C.F.R. § 164.508(b)(4)); or
- the covered entity knows that any material information included in the ROI form is false.[27]

Prohibition Against Compound Authorizations

HIPAA generally prohibits the use of "compound authorizations," with limited exceptions related to research studies and disclosure of psychotherapy notes.[28] The term "compound authorization" is not defined under HIPAA, but HHS has elsewhere described a compound authorization as a document in which an "authorization for the use and disclosure of protected health information is combined with any other legal permission."[29] For example, a single form that combines an authorization to disclose PHI and an agreement to resolve conflicts through arbitration would be an impermissible compound authorization because it merges a HIPAA authorization to disclose

25. 45 C.F.R. § 164.508(a)(3)(ii); *id.* § 164.508(a)(4)(i).
26. 45 C.F.R. § 164.508(b)(1)(ii).
27. 45 C.F.R. § 164.508(b)(2).
28. 45 C.F.R. § 164.508(b)(3).
29. *See* HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules, Final Rule, 78 Fed. Reg. 5566 (Jan. 25, 2013), https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf.

PHI with another legal permission (waiver of the client's right to a trial in favor of arbitration). A single ROI form that authorizes disclosures of PHI to multiple entities (e.g., two different healthcare providers) is not a prohibited compound authorization.

Documentation and Retention

When a covered entity seeks an ROI from an individual to allow the covered entity to disclose PHI, the covered entity must provide the individual with a copy of the signed ROI form.[30] The covered entity that discloses PHI pursuant to an ROI must retain a written or electronic copy of the ROI form for six years from the date when the ROI was created or when it was last in effect (whichever is later).[31]

Does HIPAA Allow a Guardian or Other "Personal Representative" to Authorize the Disclosure of an Adult's Confidential Information (i.e., Sign the ROI Form)?

If another person has legal authority under applicable state or federal law to make healthcare-related decisions for an adult client (e.g., a guardian of the person appointed under G.S. Chapter 35A), then HIPAA requires the covered entity to treat that person as the client's "personal representative."[32] A personal representative may exercise the rights that would normally be held by the client when it comes to the use and disclosure of the client's PHI.[33] A client's personal representative may therefore sign an ROI form for the disclosure of the client's PHI if the personal representative's authority to sign on behalf of the client is documented on the ROI form.[34]

In some situations, a HIPAA covered entity may have concerns about allowing a caregiver or family member to sign an ROI on behalf of a vulnerable adult, even if that person has legal authority to make healthcare decisions on behalf of the adult. For adult clients, a HIPAA covered entity may choose *not* to recognize a personal representative's authority to authorize the disclosure of the client's PHI if

- the covered entity has a reasonable belief that the client has been or may be subjected to domestic violence, abuse, or neglect by the personal representative or has a reasonable belief that allowing the person to act as the client's personal representative in this circumstance could endanger the client; and
- the covered entity, in the exercise of professional judgment, decides that it is not in the client's best interest to allow the person to act as the client's personal representative in this circumstance.[35]

30. 45 C.F.R. § 164.508(c)(4).

31. 45 C.F.R. § 164.530(j)(1)–(2).

32. HIPAA does not define "personal representative." However, 45 C.F.R. § 164.502(g)(2) describes a personal representative as someone who has authority under applicable law "to act on behalf of an individual . . . in making decisions related to health care."

33. 45 C.F.R. § 164.502(g)(1)–(2).

34. 45 C.F.R. § 164.508(c)(1)(vi).

35. 45 C.F.R. § 164.502(g)(5). Covered entities that choose not to recognize a personal representative's authority in these circumstances are encouraged to consult with an attorney.

Does HIPAA Allow a Parent, Guardian, or Caretaker to Authorize the Disclosure of a Minor's Confidential Information (i.e., Sign the ROI Form)?

It depends. The general rule is that the party who consented to the health service is the party that is authorized to make decisions about the use and disclosure of information related to that health service.[36] Most minors will have a parent or a parent substitute (e.g., a legal guardian or a person standing *in loco parentis*) who is authorized under applicable law to make healthcare-related decisions for the minor. When a parent or parent substitute consents to the provision of health services to the minor, the parent or parent substitute must be treated as the minor's "personal representative" under HIPAA for the purpose of authorizing disclosures of PHI related to those health services.[37]

There is an exception, however, for situations where the minor's parent or parent substitute has agreed to confidentiality between the HIPAA-covered healthcare provider and the minor regarding the health services provided. In these situations, it is the minor, not the minor's personal representative, who is the appropriate party to authorize disclosure of the minor's PHI about those health services.[38]

There are also situations where a minor may consent on their own to a health service without needing the concurrent consent of a personal representative (i.e., a parent or parent substitute). Under G.S. 90-21.5, and subject to certain limitations, minors with decisional capacity can consent to medical health services for the prevention, diagnosis, and treatment of venereal and other reportable diseases, pregnancy, abuse of controlled substances or alcohol, and emotional disturbance.[39] Here, because the minor is the party that consented to the health service, HIPAA requires the covered entity to treat the minor as the party with authority to make decisions about the disclosure of PHI related to that specific health service.[40]

It is possible that an MDT member who works for a covered entity will find themself in a situation where they want to share two types of PHI about a minor with other members of the MDT: (1) PHI related to a health service the minor received on their own consent under G.S. 90-21.5(a) (North Carolina's minor's consent law) and (2) PHI related to health services for which the minor's personal representative gave consent. In these instances, the covered entity should use two ROI forms: one for the minor to sign to permit the release of PHI related to the health service received under G.S. 90-21.5(a) and another for the minor's personal representative to sign for the release of other PHI. Covered entities should also be careful to avoid inadvertently notifying the minor's personal representative about a health service received under G.S. 90-21.5(a) without the minor's permission during the process of having the ROI forms signed.

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36. *See generally* 45 C.F.R. § 164.502(g).
37. 45 C.F.R. § 165.502(g)(3).
38. 45 C.F.R. § 164.502(g)(3)(i)(C).
39. G.S. 90-21.5. Another state law, G.S. 90-21.4(b), prohibits a provider who treats a minor under G.S. 90-21.5 from notifying the minor's parent or parent substitute about services received under G.S. 90-21.5 without the minor's permission, unless the situation, in the opinion of the attending physician, indicates that notifying the minor's parent or parent substitute is essential to the life or health of the minor.
40. 45 C.F.R. § 164.502(g)(3)(i)(A).

A covered entity may sometimes have concerns about allowing a minor's parent or parent substitute to authorize the disclosure of the minor's PHI. As with adult clients, a covered entity may choose *not* to recognize the authority of a minor's parent, guardian, or caretaker to act as the minor's personal representative and authorize the use or disclosure of the minor client's PHI if

- the covered entity has a reasonable belief that the minor has been or may be subjected to domestic violence, abuse, or neglect by the personal representative or has a reasonable belief that allowing the person to act in this circumstance as the minor's personal representative could endanger the minor; and
- the covered entity, in the exercise of professional judgment, decides that it is not in the minor's best interest to allow the person to act as the minor's personal representative in this circumstance.[41]

Does HIPAA "Follow" the Protected Information (i.e., Do Recipients of the Information Have to Comply with This Law When It Comes to Use and Redisclosure of the Information)?

No, HIPAA's requirements do not "follow" PHI once it is disclosed. Only HIPAA covered entities and their business associates are required to comply with HIPAA. If PHI is shared between two HIPAA covered entities, then both parties, by virtue of both being subject to HIPAA, must protect, use, and disclose the PHI in accordance with HIPAA. By contrast, if a covered entity shares PHI with an organization that is *not* a HIPAA covered entity or business associate, then the PHI provided by the covered entity will cease to be protected by HIPAA once it is in the hands of the receiving organization. The receiving organization may then further use or disclose the information as permitted by any other applicable law.

North Carolina's Communicable Disease Confidentiality Law (G.S. 130A-143)

Which Agencies and Organizations Are Subject to the North Carolina Communicable Disease Confidentiality Law?

North Carolina's communicable disease confidentiality law, which is found at G.S. 130A-143, protects the confidentiality of certain communicable disease information regardless of whether that information is "publicly or privately maintained," but does not identify specific individuals, agencies, or organizations that are subject to the statute. This means that all individuals, agencies, and organizations in possession of communicable disease information protected by this statute must comply with the law's confidentiality requirements.

What Information Does the North Carolina Communicable Disease Confidentiality Law Protect?

The law protects "[a]ll information and records, whether publicly or privately maintained, that identify a person who has or may have a disease or condition required to be reported" under North Carolina law. The North Carolina Commission for Public Health has established a list of reportable communicable diseases and conditions that can be found in Chapter 10A of the North Carolina Administrative Code (hereinafter N.C.A.C.).[42] This list currently includes syphilis,

41. 45 C.F.R. § 164.502(g)(5). Covered entities that choose not to recognize a personal representative's authority in these circumstances are encouraged to consult with an attorney and may have mandatory reporting obligations under North Carolina law related to the suspected abuse or neglect.

42. 10A N.C.A.C. 41A, § .0101. The North Carolina Commission for Public Health has established this list pursuant to its authority under G.S. 130A-134.

gonorrhea, HIV infection, chickenpox, botulism, tuberculosis, polio, rabies, meningitis, malaria, measles, mumps, Lyme disease, smallpox, typhoid, whooping cough, Zika, and many other diseases and conditions.

Some holders of confidential communicable disease information are also subject to HIPAA and must therefore also consider whether the information would be considered individually identifying under the HIPAA Expert Determination or Safe Harbor methods of deidentification. Agencies and organizations that are not subject to HIPAA but that hold confidential communicable disease information may have a harder time assessing whether the information could be used to "identify a person." North Carolina's communicable disease confidentiality law does not define what it means for records or information to "identify" a person who has or may have one of these reportable diseases or conditions and does not include a deidentification standard. Even though they are not required to comply with HIPAA, agencies and organizations in this position could elect to apply HIPAA's Safe Harbor standard for deidentification as a straightforward, quick method for assessing whether the communicable disease information in their possession might be individually identifying.[43]

Can Information Protected by the North Carolina Communicable Disease Confidentiality Law Be Disclosed with Client Consent?

Yes. G.S. 130A-143(2) allows for a client's communicable disease information to be released if the client or the client's personal representative provides written consent to the disclosure.

What Are the Requirements Under the North Carolina Communicable Disease Confidentiality Law for a Valid ROI Form?

North Carolina's communicable disease confidentiality law does not specify any required elements for an ROI form to release communicable disease information, other than that it must be written. The statute does not specify that the ROI form be revocable. However, permitting a client to revoke an ROI form related to the disclosure of communicable disease information is considered best practice. In the field, many providers use an ROI form that includes the elements required under HIPAA.

Does the North Carolina Communicable Disease Confidentiality Law Allow a Guardian or Other "Personal Representative" to Authorize the Disclosure of an Adult's Confidential Information (i.e., Sign the ROI Form)?

Yes. G.S. 130A-143(2) allows the release of an individual's communicable disease information if written consent for disclosure is given by that individual's "personal representative," as defined in 45 C.F.R. § 164.502 (HIPAA).[44] If another person has legal authority under applicable state or federal law to make healthcare-related decisions for an adult client (e.g., a guardian of the person appointed under G.S. Chapter 35A), HIPAA generally requires the covered entity to treat that person as the client's "personal representative" with respect to any PHI relevant to those decisions.[45] Please see the earlier section on HIPAA for further details.

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43. For additional information about methods for deidentification of health information under HIPAA, please see HHS, Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html.

44. The term "personal representative" is not defined under HIPAA, although it is used in the context of authorizations and disclosures in 45 C.F.R. § 164.502(g).

45. 45 C.F.R. § 164.502(g)(1)–(2).

Does the North Carolina Communicable Disease Confidentiality Law Allow a Parent, Guardian, or Caretaker to Authorize the Disclosure of a Minor's Confidential Information (i.e., Sign the ROI Form)?

It depends. The law permits disclosure of confidential communicable disease information with the consent of the person who is the subject of the information (i.e., the minor) or that individual's personal representative, consistent with 45 C.F.R. § 164.502.

Under HIPAA, the general rule is that the party who consented to the health service is the party that is authorized to make decisions about the use and disclosure of information related to that service.[46] Most minors will have a parent or a parent substitute (e.g., a legal guardian or a person standing *in loco parentis*) who is authorized under applicable law to make healthcare-related decisions for the minor. When a parent or parent substitute consents to the provision of health services to the minor, the parent or parent substitute should be treated as the minor's "personal representative" for the purpose of authorizing disclosures of information about those health services.[47]

There are situations where a minor may consent on their own to a health service without needing the concurrent consent of a personal representative (i.e., a parent or parent substitute). Under G.S. 90-21.5, and subject to certain limitations, minors with decisional capacity can consent to medical health services for the prevention, diagnosis, and treatment of venereal and other reportable diseases, pregnancy, abuse of controlled substances or alcohol, and emotional disturbance.[48] If a minor consents to any such health service, then the minor is the party with authority to make decisions about the disclosure of any communicable disease information related to that specific service.[49]

Does This Law "Follow" the Protected Information (i.e., Do Recipients of the Information Have to Comply with This Law When It Comes to Use and Redisclosure of the Information)?

Yes. There is a common misconception that G.S. 130A-143 only applies to healthcare providers or public health agencies. In fact, the law applies to "[a]ll information and records, whether publicly or privately maintained, that identify a person who has or may have a disease or condition required to be reported pursuant to the provisions of this Article."[50] This means that all partners within an MDT that receive confidential communicable disease information must protect, use, and disclose that information in compliance with G.S. 130A-143.

North Carolina's Mental Health, Developmental Disabilities, and Substance Abuse Confidentiality Law (G.S. 122C-52 through -56)

The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 (G.S. Chapter 122C) governs mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. Sections 52 through 56 of G.S. Chapter 122C govern the confidentiality of client information related to those services.[51]

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46. *See generally* 45 C.F.R. § 164.502(g).
47. 45 C.F.R. § 165.502(g)(3).
48. Another state law, G.S. 90-21.4(b), prohibits notifying a minor's parent or parent substitute about services received under G.S. 90-21.5 without the minor's permission, unless the situation, in the opinion of the attending physician, indicates that notifying the minor's parent or parent substitute is essential to the life or health of the minor.
49. 45 C.F.R. § 164.502(g)(3).
50. G.S. 130A-143.
51. G.S. 122C-52 through -56.

The unauthorized disclosure of information that is confidential under the state MH/DD/SA confidentiality law is a Class 3 misdemeanor[52] and could result in civil liability for a treatment professional.[53] Further, employees of "area and state facilities" are subject to disciplinary action if they disclose information in violation of G.S. Chapter 122C.[54]

Which Agencies and Organizations Are Subject to the State MH/DD/SA Confidentiality Law?

G.S. Chapter 122C and its confidentiality provisions apply to any "facility"—meaning any individual, agency, company, area authority, or state facility—at one location *whose primary purpose* is to provide services for the care, treatment, habilitation, or rehabilitation of individuals with mental illnesses, intellectual or other developmental disabilities, or substance use disorders.[55] This definition applies to individual practitioners and group practices, whether public or private. It applies whether or not the "facility" is a HIPAA covered entity.[56] It includes providers of outpatient as well as inpatient services, state-operated and privately operated psychiatric hospitals, psychiatric residential treatment centers, and organizations and individuals who contract with area authorities to provide MH/DD/SA services to area authority clients.

An "area authority" is commonly referred to as a "local management entity/managed care organization" or LME/MCO. Though these terms have distinct meanings in some contexts, for the purposes of this bulletin, the terms are interchangeable and refer to the public authorities responsible for contracting for the provision of publicly funded MH/DD/SA services within a specified geographic service area.[57]

In addition to the confidentiality requirements set out in G.S. Chapter 122C, the regulations implementing those statutory provisions impose additional confidentiality requirements on a subset of MH/DD/SA "facilities": area authorities, state facilities, and the individuals and agencies that contract to provide services on behalf of area authorities and state facilities.[58]

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52. *See* G.S. 122C-52(e).

53. The unauthorized disclosure of a patient's confidences by a physician, psychiatrist, psychologist, marital and family therapist, or other healthcare provider constitutes medical malpractice. *See* Watts v. Cumberland Cnty. Hosp. Sys., Inc., 75 N.C. App. 1, 9–11 (1985) (holding that malpractice consists of any professional misconduct or lack of fidelity in professional or fiduciary duties, including breach of duty to maintain confidentiality of patient information), *rev'd in part on other grounds*, 317 N.C. 321 (1986).

54. *See* 10 N.C.A.C. 26B, § .0104.

55. *See* G.S. 122C-3(14).

56. *Id.* "Facility" includes a professional or group of professionals in a public health department, primary care practice, or community hospital whose primary purpose is to provide services for mental illness or substance use disorder. See the School of Government online training program "Confidentiality of Behavioral Health Information for HIPAA Covered Entities in North Carolina," at https://www.sog.unc.edu/sog_modules/behavioral_health_confidentiality_laws/story.html.

57. *See* G.S. 122C-3(20b) ("Local management entity (LME). — An area authority."). *See also id.* § 3(1), 3(20c).

58. *See* 10A N.C.A.C. 26B. Many MH/DD/SA professionals work in agencies or organizations *other than* "area" or "state" facilities or their contracted service providers. For example, a mental health or substance use professional could work in or for a jail, health department, hospital, or other general medical facility. These professionals would fall within the definition of "facility" and be subject to the confidentiality provisions of G.S. Chapter 122C. But if they are not employed or contracted by an area or state facility, the confidentiality regulations at 10A N.C.A.C. 26B would not apply to them. (There is one exception: the definition of "legitimate role in the therapeutic services offered" applies to all facilities, as this term is not defined in G.S. Chapter 122C.) *See* 10A N.C.A.C. 26B, §§ .0101, .0103(b)(7), .0110.

What Information Does the State MH/DD/SA Confidentiality Law Protect?

Any information, whether recorded or not, relating to an individual served by a "facility" and received in connection with the performance of any function of the facility is confidential and may not be disclosed except as authorized by law.[59] This could include, for example, information about an identified individual's mental health diagnosis or treatment, their third-party payer, or financial status. It would also include information that identifies someone, either directly or by reference to publicly known information, as a recipient of mental health, developmental disabilities, or substance abuse services.[60]

Can Information Protected by G.S. Chapter 122C Be Disclosed with Client Consent?

Yes. A facility may disclose confidential information if the client or the client's legally responsible person consents in writing to the release of the information.[61] The state regulations that apply to area authorities and their contracted service providers require that consent be voluntary, informed, and in writing.[62] The client's consent is revocable and permits, but does not require, a facility to disclose confidential information.[63]

Any ROI form used for the disclosure of information that is confidential under G.S. Chapter 122C will often need to conform to both G.S. Chapter 122C and the HIPAA privacy rule requirements for patient authorization, as most MH/DD/SA providers in North Carolina are covered entities under HIPAA.[64]

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59. G.S. 122C-3(9) defines "confidential information." G.S. 122C-52(b) provides that no confidential information may be disclosed except as provided by G.S. 122C-53 through -56. Implementing regulations at 10A N.C.A.C. 26B, which apply to area and state facilities and their contracted providers, further detail the requirements for the collection, storage, and dissemination of confidential information.

60. G.S. 122C-3(9).

61. *See* G.S. 122C-53(a).

62. 10A N.C.A.C. 26B, §§ .0202, .0205. *See also* N.C. Dep't of Health & Hum. Servs., Div. of Mental Health, Developmental Disabilities, & Substance Abuse Servs., Records Management, Records Management and Documentation Manual for Providers of Publicly-Funded Mental Health, Intellectual or Developmental Disabilities, and Substance Use Services and Local Management Entities-Managed Care Organizations, APSM 45-2, at 11-5 (eff. Dec. 1, 2016), https://www.ncdhhs.gov/rmanddm-3rd-edition-9-1-16/open.

63. G.S. 122C-53(a).

64. HIPAA covered entities that provide services for mental illness, developmental disabilities, or substance use disorder are subject to the confidentiality provisions of G.S. Chapter 122C. See the School of Government online training program "Confidentiality of Behavioral Health Information for HIPAA Covered Entities in North Carolina," at https://www.sog.unc.edu/sog_modules/behavioral_health_confidentiality_laws/story.html.

What Are the Requirements of G.S. Chapter 122C for a Valid ROI Form?

An ROI form that contains the "core elements" for authorizations set forth in HIPAA[65] and that is subject to revocation by the consenting individual is valid consent for the disclosure of confidential MH/DD/SA information governed by G.S. Chapter 122C.[66] HIPAA's core elements are

- a description of the information that may be disclosed pursuant to the authorization;
- the name of the person(s), or class of persons, authorized to make the disclosure;
- the name of the person(s), or class of persons, permitted to receive the disclosed information;
- a description of each purpose for the disclosure;
- an expiration date or expiration event that relates to the individual or the purpose of the disclosure; and
- the signature of the client or his or her legal representative and the date of signature.[67]

It is important to note that HIPAA sets forth its ROI content requirements in two separate subsections, one pertaining to "core elements" and one listing "required statements." Both are discussed above in the section on HIPAA's ROI requirements. G.S. Chapter 122C imposes *only* the core elements on MH/DD/SA providers.[68] However, most MH/DD/SA providers in North Carolina are subject to both the HIPAA privacy rule and the state MH/DD/SA confidentiality law. Because these providers must use ROI forms that contain both the "core elements" and "required statements" set forth in HIPAA, and because some of HIPAA's "required statements" pertain to state law requirements for consent that are not specific ROI *content* requirements, HIPAA's required statements and their relation to state law deserve further discussion.

- *A statement about the client's right to revoke the ROI.* Unlike HIPAA, G.S. Chapter 122C does not specifically require this statement to be included in an ROI form authorizing the release of MH/DD/SA information. However, G.S. Chapter 122C does state that, as a matter of law, consent is subject to revocation by the client.[69] Therefore, if the goal of an ROI form is to fully and accurately inform clients of their rights related to consent, a statement about the right to revoke should be included as an element on the ROI form used by MH/DD/SA providers, even if those providers are not *required* by state law to include it. If the MH/DD/SA service provider is a covered entity under HIPAA, a statement about the client's right to revoke *would* be required by HIPAA.

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65. 45 C.F.R. § 164.508(c)(1) outlines the core elements required for a HIPAA authorization form.

66. G.S. 122C-53(a). The North Carolina Administrative Code, which applies to a subset of MH/DD/SA service providers, includes content requirements for the ROI form that differ from the core elements of HIPAA authorizations. However, this rule has been superseded by a recent amendment to G.S. 122C-53(a). *See* S.L. 2023-95 (H484), effective Oct. 1, 2023. A form that contains HIPAA's core elements and is subject to revocation is now sufficient. *See* Kirsten Leloudis and Mark Botts, *S.L. 2023-95: Changes to Patient Consent for Releasing Behavioral Health Information*, Coates' Canons: NC Local Government Law (blog) (Feb. 21, 2024), https://canons.sog.unc.edu/2024/02/sl-2023-95-roi/.

67. 45 C.F.R. § 164.508(c)(1).

68. *See* G.S. 122C-53(a) and S.L. 2023-95 (H484), effective October 1, 2023. An ROI form that contains HIPAA's core elements and is subject to revocation is a valid ROI.

69. *See* G.S. 122C-53(a).

- *A statement about the covered entity's ability or inability to condition treatment, payment, enrollment, or benefits eligibility based on whether the individual signs the authorization.* State MH/DD/SA confidentiality law does not require this statement to be included in the written ROI form. However, state law requires that, prior to obtaining consent for release of confidential information, an employee or contractor of an area or state facility must "inform the client or his or her legally responsible person that the provision of services is not contingent upon such consent and of the need for such release."[70] One way to inform the client would be to include this statement in the ROI form. If the provider of MH/DD/SA services is a HIPAA covered entity, the statement *must* be included.
- *A statement about the potential for redisclosure of the individual's PHI.* This statement is not required by state MH/DD/SA law. If the provider of services is a covered entity under HIPAA, the statement is required.
- *A statement about remuneration to the covered entity, as applicable.* State MH/DD/SA confidentiality law does not require this statement. As explained earlier, if the MH/DD/SA service provider is a covered entity under HIPAA, this statement, under certain circumstances, would be required.

The North Carolina Administrative Code contains provisions relating to a client's consent for the release of information that govern matters beyond the required *content* for an ROI form. For example, the Code includes provisions addressing who may sign the ROI form, the requirement to place a copy of the ROI form in the client record, and the requirement to inform the client or legally responsible person that the provision of services is not contingent upon signing an ROI.[71] Area and state facilities, along with their contracted providers of MH/DD/SA services, must abide by these non-content-related requirements when the client signs an ROI form.[72]

Does the State MH/DD/SA Confidentiality Law Allow a Guardian or Other "Personal Representative" to Consent to the Disclosure of an Adult's Confidential Information (i.e., Sign the ROI Form)?

Yes. When the client is an adult who is determined to be "incompetent" or "incapable," any rights or duties conferred on the client by the state confidentiality law—including the right to authorize the disclosure of confidential information—must be exercised by the client's "legally responsible person."[73]

An "incompetent" adult is an individual who has been adjudicated incompetent by a court under North Carolina's guardianship statutes (G.S. Chapter 35A).[74] The legally responsible person for an incompetent adult is the individual appointed as the client's guardian of the person or

70. 10A N.C.A.C. 26B, § .0205.

71. 10A N.C.A.C. 26B, §§ .0202, .0203, .0205, .0207.

72. *See also* N.C. Dep't of Health & Hum. Servs., Div. of Mental Health, Developmental Disabilities, & Substance Abuse Servs., Records Management, Records Management and Documentation Manual for Providers of Publicly-Funded Mental Health, Intellectual or Developmental Disabilities, and Substance Use Services and Local Management Entities-Managed Care Organizations, APSM 45-2, at 11-5 (eff. Dec. 1, 2016), https://www.ncdhhs.gov/rmanddm-3rd-edition-9-1-16/open.

73. G.S. 122C-4; *id.* § 3(20); *id.* § 53(a).

74. G.S. 122C-3(17).

general guardian under G.S. Chapter 35A.[75] Therefore, when authorization is needed to disclose confidential information and the client is an adult who has been adjudicated incompetent, the client's guardian of the person or general guardian must sign the ROI form.

An "incapable" adult is an individual who, in the opinion of a physician or eligible psychologist, currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions.[76] The legally responsible person for an incapable adult who has no guardian is the healthcare agent named in the client's healthcare power of attorney.[77]

It is important to note that the authority of a healthcare agent named in a healthcare power of attorney may be episodic. When a client who has a valid healthcare power of attorney lacks decisional capacity, the healthcare agent has authority to sign the ROI form.[78] However, when a client who has executed a healthcare power of attorney has decisional capacity (has not lost the capacity to understand and communicate treatment decisions or has regained such capacity), it is the client, not the healthcare agent, who is authorized to sign the ROI form.[79] The healthcare agent is a legally responsible person for the client *only when the client lacks decisional capacity.* The healthcare agent's authority to act on behalf of the client ceases if the client regains decisional capacity.[80]

For an adult who lacks decisional capacity but has not been adjudicated incompetent by a court and has no healthcare power of attorney, the treatment provider must refer to a state law applicable to healthcare generally to identify a legally responsible person for the client.[81] That law, G.S. 90-21.13(c)(3) through (7), lists in priority order the individuals authorized to make treatment decisions on behalf of the incapable adult: an agent with powers to make healthcare decisions appointed by the patient, the patient's spouse, a majority of the patient's reasonably available parents and children who are at least 18 years of age, a majority of the patient's reasonably available siblings who are at least 18 years of age, or an individual who has an established relationship with the patient; is acting in good faith; and can reliably convey the patient's wishes.[82] A person authorized to make treatment decisions for the client under this law is considered a legally responsible person and is authorized to sign an ROI form on behalf of the client.[83]

Does G.S. Chapter 122C Allow a Parent, Guardian, or Caretaker to Consent to the Disclosure of a Minor's Confidential Information (i.e., Sign the ROI Form)?

Yes, but in some situations, only the minor is authorized to sign the ROI form. Generally, the person who gives informed consent to treatment is the person who has the authority to consent to the disclosure of records related to that treatment. When a parent or other "legally responsible person" consents to *treatment* on behalf of their minor child, then the authority to consent to the *disclosure of information* relating to that treatment is held by that legally responsible person.[84]

75. G.S. 122C-3(15), (20).
76. G.S. 122C-3(16b); *id.* § 72(4).
77. G.S. 122C-2(20); *id.* § 4(b).
78. G.S. 32A-20(a); *id.* § 3(20); *id.* § 4(b); *id.* § 53(a).
79. G.S. 32A-20(a); *id.* § 3(20); *id.* § 4(b); *id.* § 53(a).
80. G.S. 32A-20(a).
81. G.S. 122C-3(20).
82. G.S. 90-21.13(c)(3) through (7).
83. G.S. 122C-3(20); *id.* § 4; *id.* § 53(a).
84. G.S. 122C-4; *id.* § 3(20); *id.* § 57(d); *id.* § 53(a).

If the information to be disclosed under the ROI pertains to or was acquired in the course of providing treatment or services that the minor's legally responsible person consented to, then the minor's legally responsible person must sign the ROI. When applied to a minor client, "legally responsible person" refers to a parent, guardian,[85] person standing *in loco parentis*,[86] or legal custodian other than a parent who has been granted specific authority by law or in a custody order[87] to consent for medical care, including psychiatric treatment.[88]

There are exceptions to the general rule. When a minor consents to his or her own treatment, as authorized in certain instances,[89] then the minor client alone, not the minor client's legally responsible person, must sign the ROI form.

State law allows minors with decisional capacity to consent to medical health services for the prevention, diagnosis, and treatment of venereal and other reportable diseases, pregnancy, abuse of controlled substances or alcohol, and emotional disturbance.[90] This includes outpatient services for mental illness or substance use disorder. If the minor consents to these treatment services, then the MH/DD/SA provider must seek the minor's consent to disclose confidential information related to that treatment.[91] However, the minor's authority to consent to treatment under G.S. 90-21.5(a) does not extend to admission or treatment in an *inpatient* psychiatric or substance use disorder facility.[92] A parent or other legally responsible person must consent to admission and treatment at these facilities and, therefore, must also sign any consent to release information held by inpatient facilities.

Does the State MH/DD/SA Confidentiality Law "Follow" the Protected Information (i.e., Do Recipients of the Information Have to Comply with This Law When It Comes to Use and Redisclosure of the Information)?

Yes. "No individual" having access to confidential information may disclose it except as authorized by G.S. Chapter 122C.[93] This duty of confidentiality is not limited to MH/DD/SA facilities or treatment providers. The duty extends to any "individual having access to

85. G.S. 7B-600(a) authorizes a court to appoint a guardian of the person for a juvenile. Among other powers and duties, the guardian may "consent to any necessary remedial, psychological, medical, or surgical treatment for the juvenile." When defining "guardian," G.S. 122C-3(15) refers to a guardian appointed under G.S. Chapter 7A. Portions of that chapter were repealed, and G.S. 7B-600 was enacted by S.L. 1998-202.

86. See Kirsten Leloudis, *Who Is a "Person Standing In Loco Parentis" and When Can They Consent to Health Care for a Minor?,* Coates' Canons: NC Local Government Law (blog) (Mar. 24, 2023), https://www.sog.unc.edu/blogs/coates-canons/who-%E2%80%9Cperson-standing-loco-parentis%E2%80%9D-and-when-can-they-consent-health-care-minor.

87. When a court orders a juvenile into the nonsecure custody of the department of social services (DSS), DSS is the juvenile's legally responsible person under G.S. 122C for specific types of care. Under G.S. 7B-505.1(a)(2), the DSS director is authorized to consent to emergency mental health care and treatment for a juvenile in DSS custody. A court can also separately authorize the DSS director to consent to non-emergency mental health care for a juvenile in DSS custody under G.S. 7B-505.1(c). *See* G.S. 7B-903.1(e). In both scenarios, the DSS director may delegate the director's authority to consent to care for the juvenile to a member of the DSS director's staff. *See* G.S. 108A-14(b).

88. G.S. 122C-3(20).

89. G.S. 90-21.5(a).

90. G.S. 90-21.5(a).

91. *See* G.S. 90-21.4; 122C-4; *id.* § 53(a).

92. G.S. 90-21.5(a).

93. G.S. 122C-52(b).

confidential information," which includes individuals receiving information from a "facility" pursuant to client consent, even if the recipient of information is not a "facility." The recipient of information must apply and follow G.S. Chapter 122C when redisclosing the information.

In this respect, the state law governing MH/DD/SA records is unlike HIPAA but similar to the federal law governing substance use disorder records. When a HIPAA covered entity, pursuant to client consent, discloses HIPAA-protected information to a person or entity that is not a covered entity or business associate of a covered entity, the recipient of information is not bound by the confidentiality provisions of HIPAA. But under 42 C.F.R. Part 2, the duty of confidentiality attaches to the information and passes to the recipient except in certain circumstances.[94] An individual having access to information protected by G.S. Chapter 122C or 42 C.F.R. Part 2 may redisclose it only as specifically permitted or required by those laws.

There is an important qualification to the state law provision requiring any individual having access to confidential information to disclose it *only* in accordance with G.S. 122C-52 through -56. If the recipient of information is a HIPAA covered entity or business associate who has received the information pursuant to a provision of G.S. 122C-53 through -56, the recipient may use and disclose such information as permitted or required by the HIPAA privacy rule.[95] Unlike recipients who are not HIPAA covered entities or business associates, a HIPAA covered entity or business associate may redisclose such information as permitted by the HIPAA privacy rule without regard to the restrictions on disclosure in G.S. Chapter 122C.

Federal Law Governing the Confidentiality of Substance Use Disorder Records (42 C.F.R. Part 2)

Federal law imposes restrictions on the use and disclosure of substance use disorder (SUD) patient records.[96] The purpose of this law is to encourage individuals with a substance use disorder to seek treatment without fear of stigma, discrimination, or other adverse consequences that could arise from disclosing information in the course of seeking treatment.[97] Except as permitted by 42 C.F.R. Part 2, the disclosure of patient information by an SUD program—and in some cases, by individuals or entities who receive information from such a program—is prohibited.[98] Anyone who discloses patient information in violation of this confidentiality law is subject to civil and criminal penalties.[99]

94. See the "Federal Law Governing the Confidentiality of Substance Use Disorder Records" section of this bulletin.

95. G.S. 122C-52(b). The covered entity or business associate may use and disclose the information as permitted or required by 45 C.F.R. pt. 164, subpt. E.

96. See 42 U.S.C. § 290dd-2 and its implementing regulations at 42 C.F.R. pt. 2.

97. 42 C.F.R. § 2.2. *See* HHS, Confidentiality of Substance Use Disorder (SUD) Patient Records, Final Rule, 89 Fed. Reg. 12,484 (Feb. 16, 2024), https://www.federalregister.gov/d/2024-02544/page-12484.

98. 42 C.F.R. § 2.2(b)(1), § 2.13(a).

99. 42 C.F.R. § 2.3(a). The provisions for enforcing HIPAA, found at 45 C.F.R. § 160, subpts. C, D, and E, apply to noncompliance with the federal SUD confidentiality law. 42 C.F.R. § 2.3(c).

Which Agencies and Organizations Are Subject to the Federal SUD Confidentiality Law?

42 C.F.R. Part 2 governs federally assisted "programs."[100] A "program" is

1. a person or entity (other than a general medical facility) that holds itself out as providing, and provides, substance use disorder[101] diagnosis, treatment, or referral for treatment;
2. an identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
3. medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.[102]

A program is considered "federally assisted" if it participates in Medicare, has tax-exempt status, is registered to dispense a controlled substance used in the treatment of substance use disorders, receives federal financial assistance in any form (even if the financial assistance does not directly pay for substance use disorder treatment), or is a local government unit that receives federal funds that could be (but are not necessarily) spent for a substance abuse disorder program.[103] By participating in Medicaid and receiving federal block grant funding, North Carolina's public mental health authorities (LME/MCOs) and the agencies that contract with them to provide substance use disorder diagnosis, treatment, or referral for treatment are federally assisted programs governed by 42 C.F.R. Part 2.

Programs that are not federally assisted are not bound by the regulations. If a patient's substance use disorder diagnosis, treatment, or referral for treatment is provided by a program that is not federally assisted, then that patient's record is not covered by the regulations. However, programs that are federally assisted are bound by 42 C.F.R. Part 2. The regulations refer to these programs as "Part 2 programs."[104]

Assuming they are federally assisted, examples of Part 2 programs include treatment or rehabilitation programs, employee assistance programs, programs in general hospitals, and school-based programs that hold themselves out as providing and do provide substance use disorder diagnosis, treatment, or referral for treatment.[105] A private practitioner who specializes in (and holds herself out as specializing in) *diagnosing* substance use disorders and referring patients elsewhere for treatment is also covered by 42 C.F.R. Part 2 even though she does not directly *treat* substance use disorders.

As listed above there are three independent ways that a person or entity may fall within the definition of "program." Two of these definitions apply to "general medical facilities," a term not defined in the regulations. Based on the definitions of "program" above, if a general or acute care hospital is considered a general medical facility, then 42 C.F.R. Part 2 would not apply to hospital emergency department personnel who refer a patient to the hospital's intensive care unit for an apparent drug overdose unless the *primary* function of the emergency department personnel is to provide substance use disorder diagnosis, treatment, or referral for treatment, and they are identified as providing such services (see the third definition of "program" above.) On the other

100. *See* 42 C.F.R. § 2.2(a).
101. *See* 42 C.F.R. § 2.11 (definition of "substance use disorder").
102. 42 C.F.R. § 2.11.
103. *See* 42 C.F.R. § 2.12(b).
104. 42 C.F.R. § 2.11.
105. *See* 42 C.F.R. § 2.12(e)(1).

hand, if, after the patient is transferred to a medical floor, a substance use professional visits and evaluates the patient for a substance use disorder and possible referral for treatment, the substance use professional would clearly fall within the third definition of "program" above.

A hospital emergency department could fall within the second definition of a "program." For example, if a general hospital promotes its emergency department or another identified unit, such as a detox unit, to the community as a provider of substance use disorder treatment services, then the identified unit, but not the rest of the general hospital, would be considered a program covered by the regulations. It is important to note that the term "general medical facility," in addition to applying to acute care or general hospitals, could also apply to trauma centers, federally qualified health centers, and practices comprised of primary care providers. For example, if a physician is an addictions specialist who works in a community health center that provides primary care, pregnancy care, and geriatric care, and the physician treats patients with substance use disorders and prescribes buprenorphine for opiate use disorder as part of her practice, then the physician is considered a "program" governed by 42 C.F.R. Part 2.

What Information Does 42 C.F.R. Part 2 Protect?

The federal restrictions on disclosure apply to any information, whether recorded or not, that

1. would identify[106] a patient[107] as having or having had a substance use disorder and
2. is substance use disorder information obtained by a federally assisted substance use disorder program for the purpose of treating substance use disorder, making a diagnosis[108] for that treatment, or making a referral for that treatment.[109]

The mere acknowledgment by program staff that an identified individual is receiving Part 2 program services would involve the disclosure of confidential information.[110] Likewise, the mere confirmation of the presence of an identified patient at a federally assisted residential or inpatient facility would involve the disclosure of confidential information if the program or facility is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided.[111] Acknowledging the presence of a patient in this circumstance would require either the patient's written consent or an authorizing court order issued in compliance with 42 C.F.R. Part 2.

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106. "Identify" means a communication, either written or oral, of information that identifies someone as a substance user, the affirmative verification of another person's communication of patient-identifying information, or the communication of any information from the record of a patient who has been identified.

107. A "patient" is "any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a Part 2 program. *Patient* includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder in order to determine that individual's eligibility to participate in a Part 2 program. This definition includes both current and former patients. 42 C.F.R. § 2.11.

108. "Diagnosis" means any reference to an individual's substance use disorder, or to a condition that is identified as having been caused by that use, which is made for the purpose of treatment or referral for treatment. 42 C.F.R. § 2.11. This includes any record of a diagnosis prepared in connection with treatment or referral for treatment of substance use disorder, even if the patient does not follow through with the referral or receive treatment. It does not include a diagnosis that is made solely for the purpose of providing evidence for use by law enforcement authorities, or a diagnosis of drug overdose or alcohol intoxication that clearly shows the individual involved is not an alcohol or drug abuser (e.g., in cases of involuntary ingestion of alcohol or drugs or a reaction to a prescribed dosage of one or more drugs). 42 C.F.R. § 2.12(e)(4).

109. 42 C.F.R. § 2.12(a)(1).

110. 42 C.F.R. § 2.13(c)(2).

111. 42 C.F.R. § 2.13(b), (c).

Can Information Protected by the Federal SUD Confidentiality Law Be Disclosed with Patient Consent?

Yes. A Part 2 program may disclose confidential substance use disorder information with the consent of the patient.[112] As with the HIPAA privacy rule and the state MH/DD/SA confidentiality law, patient consent must be voluntary and in writing.[113] It also must be informed, which means that the individual signing the authorization must understand what information will be shared, with whom it will be shared, and for what purpose.[114] To this end, the federal law governing substance use disorder programs specifies certain content that must be included in the written ROI form, as described in the following section.[115]

Any ROI form used for the disclosure of information that is confidential under 42 C.F.R. Part 2 should also conform to the state law requirements for disclosing confidential MH/DD/SA information, described earlier in this bulletin, since the confidentiality provisions of G.S. Chapter 122C apply to providers of substance use disorder services in North Carolina.[116] In addition, if a program governed by 42 C.F.R. Part 2 also falls within HIPAA's definition of "covered entity," HIPAA's requirements for patient authorization will apply.[117] Accordingly, most substance use disorder service providers in North Carolina must comply with the consent requirements of three laws: HIPAA, G.S. Chapter 122C, and 42 C.F.R. Part 2.[118] Rather than using three separate ROI forms, the required elements of each law can be merged, or woven together, into a single form.

What Are the Requirements Under 42 C.F.R. Part 2 for a Valid ROI Form to Disclose Confidential Information?

An ROI form for the disclosure of information that is confidential under 42 C.F.R. Part 2 must contain the following elements:[119]

- *The name of the patient.*
- *A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.*[120]
- *The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.*

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112. 42 C.F.R. §§ 2.13(a), 2.33, 2.31.

113. 42 C.F.R. § 2.33. The regulations do not expressly use the term "voluntary," but consent is valid only if it is put in writing on a form signed by the patient or other authorized person, is expressly revocable, and has not been revoked. 42 C.F.R. § 2.31. Further, the patient's written consent must be on a form that identifies, in a specific and meaningful fashion, the information to be disclosed. *Id.* Finally, the patient must agree to the purposes for which information will be disclosed and understand the consequences of a refusal to sign. *Id.* These required features for a legally valid consent are indicators of an informed and voluntary consent.

114. 42 C.F.R. § 2.31.

115. *See id.*

116. G.S. 122C-3(14); *id.* § 3(9); *id.* § 52.

117. See the "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" section in Part 2 of this bulletin.

118. For online training on all three laws, see the School of Government program "Confidentiality of Behavioral Health Information for HIPAA Covered Entities in North Carolina," at https://www.sog.unc.edu/sog_modules/behavioral_health_confidentiality_laws/story.html.

119. 42 C.F.R. § 2.31.

120. If the information to be disclosed fits the definition of "substance use disorder (SUD) counseling notes," additional requirements apply. *See* 42 C.F.R. § 2.31(b). SUD counseling notes are notes—recorded by a Part 2 program provider who is a SUD or mental health professional—that document or analyze the contents of conversations during a private SUD counseling session and that are separated from the rest of the patient's SUD medical record. *See id.* § 2.11.

- *The name of the person or entity*[121] *(or persons or entities), or class of persons or entities,*[122] *to which a disclosure is to be made.*[123]
- *A description of each purpose of the requested use or disclosure.* The statement "at the request of the patient" is a sufficient description of the purpose when a patient initiates the consent and does not, or elects not to, provide a statement of purpose.[124] The statement "for treatment, payment, and healthcare operations"[125] is a sufficient description of purpose when a patient provides consent once for all future uses or disclosures for these purposes.[126]
- *An expiration date or expiration event that relates to the individual patient or the purpose of the use or disclosure.*
- *The signature of the patient or the patient's legally authorized representative, and in some cases where the patient is a minor, the signature of both the patient and the patient's legally authorized representative.*
- *The date when the ROI form is signed.*

The foregoing requirements are substantially similar to HIPAA's core elements for an ROI form,[127] which are also required by the state MH/DD/SA confidentiality law for a client authorization to disclose confidential MH/DD/SA information. In addition, 42 C.F.R. Part 2 also requires the following statements to be included in an ROI:[128]

- *A statement about the individual's right to revoke the consent in writing, except to the extent that the Part 2 program or lawful holder has acted in reliance on it, and how the patient may revoke the ROI.* This is substantially equivalent to the statement required by HIPAA if the provider of SUD services is a HIPAA covered entity.[129]

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121. The federal SUD confidentiality law uses the term "person" and borrows HIPAA's definition for that term: "a natural person (meaning a human being who is born alive), trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private." 42 C.F.R. § 2.11; 45 C.F.R. § 160.103. An MDT could use an ROI form that identifies the recipients of information by using the names of persons, agencies, or other entities.

122. This particular requirement was modified effective April 16, 2024, with the publication of the final rule to implement section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Significantly, the federal SUD confidentiality law no longer requires that the person or entity be specifically identified by name. Now, the ROI form can identify the recipient of information by name *or* by reference to a *class* of persons. For example, for a single consent for all future uses and disclosures for treatment, payment, and healthcare operations, the recipient may be described as "my treating providers, health plans, third-party payers, and people helping to operate this Part 2 program" or a similar description. 42 C.F.R. § 2.31(a)(4).

123. If the recipient of information disclosed pursuant to the ROI is an "intermediary" (a person or entity who has received information to be disclosed to one or more of its member participants who has a treating provider relationship with the patient), specific instructions for designating recipients apply. 42 C.F.R. § 2(a)(4)(ii).

124. 42 C.F.R. § 2.31(5).

125. The terms "treatment, payment, and healthcare operations" have the same meaning as defined in HIPAA. *See* 45 C.F.R. § 164.501.

126. 42 C.F.R. § 2.31(5).

127. 45 C.F.R. § 164.508(c)(1).

128. 42 C.F.R. § 2.31(a)(5).

129. 45 C.F.R. § 508(c)(2)(i). HIPAA provides that to the extent that the covered entity's notice of privacy practices gives the exceptions to the right to revoke and describes how the individual may revoke the consent, then that information need not be included in the ROI if the ROI references the covered entity's notice of privacy practices.

- *A statement about the consequences to the client of a refusal to sign the ROI form.* This statement is required when the purpose for the use or disclosure is treatment, payment, or healthcare operations.[130]
- *A statement about the potential for the information disclosed pursuant to the consent to be no longer protected by 42 C.F.R. Part 2 and subject to redisclosure by recipient.* This statement is required when the purpose for the use or disclosure is treatment, payment, or healthcare operations.[131]
- *A statement about the patient's right to elect not to receive any fundraising communications.* This must be included only if the Part 2 program intends to use or disclose the records to fundraise on its own behalf.[132]

Consent for the use and disclosure of records in civil, criminal, administrative, or legislative proceedings cannot be combined with a consent to use or disclose a record for any other purpose.[133] A copy of the ROI form must accompany each disclosure made with the patient's written consent.[134]

Does 42 C.F.R. Part 2 Allow a Guardian or Other "Personal Representative" to Authorize the Disclosure of an Adult's Confidential Information (i.e., Sign the ROI Form)?

Generally, 42 C.F.R. Part 2 recognizes the authority of personal representatives for adults who lack the capacity to make healthcare decisions only when the lack of capacity has been adjudicated by a court.[135] Unlike state MH/DD/SA confidentiality law, 42 C.F.R. Part 2 does not appear to recognize the authority of a healthcare agent named in a patient's healthcare power of attorney to sign an ROI on the patient's behalf. Under state law, that authority arises when a clinician has determined that the adult is incapable.[136] Court involvement or adjudication is not required. Further, 42 C.F.R. Part 2 does not identify or recognize a personal representative for an adult patient who lacks decisional capacity but has not been adjudicated incompetent, other than to state that the director of a Part 2 program may exercise the right of such patient to consent to a disclosure for the sole purpose of obtaining payment for services from a third-party payer.[137]

Does the Federal SUD Confidentiality Law Allow a Parent, Guardian, or Caretaker to Authorize the Disclosure of a Minor's Confidential Information (i.e., Sign the ROI Form)?

When a minor is receiving or has received treatment for substance use disorder, 42 C.F.R. Part 2 generally follows the same rule that applies under the state MH/DD/SA confidentiality law: the person who gives informed *consent to treatment* is also the person who has the authority to *consent to the disclosure of information* related to that treatment.

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130. 45 C.F.R. § 2.31(10)(ii).

131. 45 C.F.R. § 2.31(10)(i). If the recipient of information disclosed pursuant to the ROI is a covered entity or business associate and the disclosure is for purposes of treatment, payment, or healthcare operations, the ROI must include a statement that the information may be redisclosed as permitted by HIPAA, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. 42 C.F.R. § 2.31(a)(4)(iii).

132. 42 C.F.R. § 2.31(a)(5)(iii).

133. 42 C.F.R. § 2.31(d).

134. 42 C.F.R. § 2.32(b).

135. 42 C.F.R. § 2.15(a)(1).

136. G.S. 32A-20(a).

137. 42 C.F.R. § 2.15(a)(2).

Under North Carolina law, minors with decisional capacity may consent to medical health services for the prevention, diagnosis, and treatment of abuse of controlled substances or alcohol.[138] If the confidential information involves substance use disorder treatment that the minor may legally consent to under state law, and if the minor consented to the treatment in question, then only the minor may consent to the disclosure of information related to that treatment.[139]

When a parent or other "legally responsible person"[140] consents to treatment on behalf of a minor child, 42 C.F.R. Part 2 applies a modified version of the state rule. In this situation, state law says that the authority to consent to the disclosure of a minor's MH/DD/SA services information is held by the legally responsible person.[141] The federal SUD confidentiality law states that, where state law requires the legally responsible person's *consent to treatment* for a minor to receive services for substance use disorder, any written consent to disclose information related to that treatment must be given by *both* the minor *and* the minor's legally responsible person.[142] In this situation, both the minor and the minor's legally responsible person must sign the ROI form.

Does 42 C.F.R. Part 2 "Follow" the Protected Information (i.e., Do Recipients of the Information Need to Comply with This Law Regarding Its Use and Redisclosure)?

Yes. It is important to note that, unlike with HIPAA, the confidentiality protections of 42 C.F.R. Part 2 sometimes follow, or attach to, the information that is disclosed pursuant to patient consent. As a result, the recipient of information may only use and further disclose the information as permitted or required by 42 C.F.R. Part 2.

Like the state MH/DD/SA confidentiality law, the federal SUD confidentiality law extends the duty of confidentiality beyond treatment providers to include those with whom they share information.[143] The duty of confidentiality applies not only to those who acquire or create confidential information in the course of providing services but also to those who receive confidential information from service providers pursuant to patient consent.[144] Recipients of confidential substance use disorder information are considered "lawful holders" of confidential information who are legally bound to follow 42 C.F.R. Part 2 with respect to the information they receive.[145]

The federal SUD confidentiality law modifies the duty of confidentiality for a specific subcategory of lawful holders of information who receive it pursuant to client consent. HIPAA covered entities and their business associates who receive information pursuant to patient

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138. G.S. 90-21.5(a).

139. 42 C.F.R. § 2.14(a).

140. "Legally responsible person" means a parent, guardian, person standing *in loco parentis*, or legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment. G.S. 122C-3(20).

141. G.S. 122C-4; *id.* § 3(20); *id.* § 53(a).

142. 42 C.F.R. § 2.14(b). The federal SUD law does not use the use the term "legally responsible person." It refers to a parent, guardian, "or other person authorized under state law to act on the minor's behalf." *Id.* In North Carolina, the person authorized under G.S. 122C to act on the minor's behalf is the minor's "legally responsible person." G.S. 122C-4; *id.* § 3(20); *id.* § 53(a); *id.* § 57. See note 140 for the definition of "legally responsible person."

143. 42 C.F.R. § 2.12(d). For the state rule, see G.S. 122C-52(b). For a discussion of an exception to the state rule for HIPAA covered entities, see the "North Carolina's Mental Health, Developmental Disabilities, and Substance Abuse Confidentiality Law" section of this bulletin.

144. 42 C.F.R. § 2.12(d)(1); 42 C.F.R. § 2.12(d)(2)(i)(C); 42 C.F.R. § 2.32(a)(1).

145. 42 C.F.R. § 2.11.

consent *for the purposes of treatment, payment, or healthcare operations* may further use and disclose that information as permitted by HIPAA alone.[146] Such information may be redisclosed without regard to 42 C.F.R. Part 2, except that the SUD confidentiality law's general prohibition against the use and disclosure of confidential information for civil, criminal, administrative, and legislative proceedings against the patient would continue to apply.[147] Those disclosures would be prohibited without a patient ROI or court order, both of which must specifically authorize disclosure for those particular purposes.

North Carolina's Social Services Confidentiality Law (G.S. 108A-80)

Which Agencies and Organizations Are Subject to G.S. 108A-80?

G.S. 108A-80(a) applies to "any person." However, in practice, the statute is generally interpreted to apply to government officials and employees who are involved in the administration of public assistance and social services programs or, through their official or professional roles, have access to information about individuals applying for or receiving services through these programs.[148] For example, this law applies to employees of a county department of social services (DSS) or consolidated human services agency, as well as to state officials and employees who have access to public assistance and social services program information as part of their official duties.

What Information Does G.S. 108A-80 Protect?

G.S. 108A-80(a) protects information concerning any person applying for or receiving public assistance or social services if that information

- was directly or indirectly derived from the records, files, or communications of the North Carolina Department of Health and Human Services (NCDHHS), county boards of social services, or county departments of social services; or
- was acquired in the course of performing official duties.

Among other things, this law protects any information that might identify an individual as an applicant for or recipient of public assistance or social services from a county DSS. For example, it covers information about individuals who have received social services in the context of child protective services (CPS) cases, adult protective services (APS) cases, or guardianship cases in which a county DSS serves as a public guardian. It also covers information about individuals who have applied for or received public assistance through programs such as Medicaid, Work First, or Food and Nutrition Services. While state law allows (or sometimes even requires) the disclosure of certain social services information to specific agencies, organizations, and individuals in particular circumstances, most of those exceptions are beyond the scope of this bulletin.[149]

146. 42 C.F.R. § 2.33(b)(1).

147. 42 C.F.R. § 2.12(d)(1); *id.* § 2.31(a)(4)(iii); *id.* § 2.32.

148. *See* Aimee N. Wall, Disclosing Protective Services Information: A Guide for North Carolina Social Services Agencies 13–14 (UNC School of Government, 2015).

149. For examples of some of these permissible disclosures, see Kristi Nickodem, *Internal Sharing of Information Within a County Department of Social Services*, Social Services Law Bulletin No. 50 (May 2022), https://www.sog.unc.edu/publications/bulletins/internal-sharing-information-within-county-department-social-services.

Can Information Protected by G.S. 108A-80 Be Disclosed with Client Consent?

Yes, with some important exceptions. The regulations accompanying G.S. 108A-80 are found in Title 10A, Chapter 69 of the North Carolina Administrative Code. One of those regulations, 10A N.C.A.C. 69, § .0401, permits client information "owned by" the State Division of Social Services (within NCDHHS) or a county DSS to be disclosed pursuant to a signed consent for the release of information. The requirements for that written release of information are described below.

Some social services information protected by G.S. 108A-80 is also protected by other, more restrictive confidentiality laws and *cannot* be disclosed pursuant to client consent. Three categories of such information are described below.

1. **Confidential Information About Other People.** A DSS client does not have a right to access (or consent to disclose) information that would breach another individual's right to confidentiality under state or federal law.[150]
2. **Child Protective Services Information.** G.S. 7B-302(a1) requires that *all* CPS information be held "in the strictest confidence" by DSS. The confidentiality requirement of G.S. 7B-302(a1) applies as soon as DSS receives a report of suspected child abuse, neglect, dependency, or death due to maltreatment. It covers (1) all information obtained in the report, (2) the reporter's identity, and (3) all information gathered by DSS following the report. CPS information can only be disclosed in certain limited circumstances identified in G.S. Chapter 7B[151] and 10A N.C.A.C. 70. A parent, guardian, custodian, or caretaker has no authority to consent to the disclosure of a juvenile's CPS information. Accordingly, DSS should *not* rely on an ROI form as a legal mechanism for sharing confidential CPS information with others.[152]
3. **Certain Adult Protective Services Information.** Most APS information is subject to the general confidentiality protections that apply to all social services information under G.S. 108A-80, meaning it can typically be disclosed pursuant to client consent.[153] This includes the findings of an APS evaluation, which may be disclosed with the consent of the disabled adult who is the subject of the evaluation.[154] However, there are a couple of specific categories of APS information that receive heightened confidentiality protection under other regulations or statutes and cannot be disclosed with client consent.
   a. ***Information about the identity of the reporter (or anyone who provides information to DSS in the course of an APS investigation).*** DSS is only allowed to disclose the reporter's identity in three specific situations: (1) when a court orders disclosure, (2) to the Division of Health Service Regulation when division staff

150. *See* 10A N.C.A.C. 69, § .0301(a)(3).

151. *See, e.g.*, circumstances enumerated in G.S. 7B-302(a1), (e); 7B-700; 7B-2901(b); and 7B-3100.

152. There may be provisions in G.S. Chapter 7B that allow DSS to share such information in certain circumstances, including in an MDT context. For example, under certain circumstances, G.S. 7B-3100 would allow disclosures of child protective services information to certain parties enumerated in the statute, the accompanying regulation (14B N.C.A.C. 11A, § .0301), or an administrative order entered by a chief district court judge. DSS may also share information from protective services case records with public or private agencies or individuals that are being utilized to provide or facilitate the provision of protective services to a child. *See* G.S. 7B-302(e); 10A N.C.A.C. 70A, § .0113(b). In these cases, it is a provision of law—not an ROI form—that authorizes DSS to make such disclosures.

153. Such consent must comply with the requirements of 10A N.C.A.C. 69, § .0401.

154. 10A N.C.A.C. 71A, § .0803.

request information to carry out an investigation, and (3) to the district attorney's office or law enforcement officials involved with a criminal investigation of alleged abuse, neglect, or exploitation of a disabled adult.[155]

b. ***Any copies of a disabled adult or older adult's financial records.*** These records may only be disclosed pursuant to a court order.[156]

What Are the Requirements Under G.S. 108A-80 for a Valid ROI Form to Disclose Confidential Information?

The ROI form for the disclosure of DSS information (information that may be disclosed, as described above) must include the following elements:[157]

1. the name of the provider and the recipient(s) of the information;
2. the extent of the information to be released;
3. the name and dated signature of the client;
4. a statement that the consent is subject to revocation at any time, except to the extent that action has been taken in reliance on the consent; and
5. the length of time the consent is valid.

If agreed upon by the client, the ROI form may be modified to contain additional information, including (but not limited to) the following:[158]

1. a statement specifying the date, event, or condition upon which the consent may expire, even if the client does not expressly revoke the consent; or
2. a specific purpose for the release.

Prior to obtaining consent for the release of information, the DSS director or a delegated representative must explain the meaning of informed consent.[159] As part of this process, the client must be informed of the following:[160]

1. what information may be released;
2. whether the information is needed to verify eligibility (e.g., for a particular program or service);
3. that the client can give or withhold consent, and that consent is voluntary; and
4. that there are statutes, rules, and regulations protecting the confidentiality of the client's information.

When client information is disclosed pursuant to the client's consent, the DSS director or the director's delegated representative must document the reason for the disclosure in the client's record, including placing a copy of the signed ROI form in the client's record.[161]

155. 10A N.C.A.C. 71A, § .0802.
156. G.S. 108A-116(d).
157. 10A N.C.A.C. 69, § .0401(d); *see also* G.S. 108A-14(b) (DSS director's delegation to DSS staff).
158. 10A N.C.A.C. 69, § .0401(e).
159. 10A N.C.A.C. 69, § .0401(g).
160. *Id.*
161. 10A N.C.A.C. 69, § .0401(i).

Does G.S. 108A-80 Allow a Guardian or Other "Personal Representative" to Authorize the Disclosure of an Adult's Confidential Information (i.e., Sign the ROI Form)?

The following persons may consent to the release of an adult DSS client's information:[162]

1. ***The client.*** In addition to the client consenting on the client's own behalf, the term "client" also includes any 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."[163]
2. ***The legal guardian of a client who has been adjudicated incompetent.*** In addition to applying to other legal guardians, the definition of "client" would presumably allow a DSS director to consent to the disclosure of a client's information when DSS has been appointed as the guardian of the person or general guardian of the client.[164]

There is, however, an important limitation on what a legal guardian (including DSS) or any other person "acting on behalf of the client" can authorize DSS to share. Specifically, someone "acting on behalf of the client" cannot authorize DSS to disclose "specific findings" included in DSS's APS evaluation when evaluating any report of abuse, neglect, or exploitation of a disabled adult. Under state law, these specific findings may only be disclosed pursuant to the consent of "the disabled adult."[165] This arguably does not include someone exercising their right to act *on behalf of* the disabled adult.[166] However, DSS may disclose the specific findings of an APS evaluation to the extent necessary to provide protective services to the disabled adult, which, in some cases, may include disclosing those findings to a multidisciplinary team working on the adult's case.[167]

Another limitation arises in the CPS context. An adult may be receiving services from DSS as a result of involvement in a CPS case (for example, a parent of a juvenile who is the subject of an abuse, neglect, or dependency report). In such a scenario, neither the adult nor the adult's legal guardian can consent to the disclosure of information about the CPS case via an ROI form, as this type of disclosure is not allowed by G.S. 7B-302(a1).

Does G.S. 108A-80 Allow a Parent, Guardian, or Caretaker to Authorize the Disclosure of a Minor's Confidential Information (i.e., Sign the ROI Form)?

This depends on whether the minor's confidential information is CPS information (as described earlier in this section) or *other* information DSS holds about a minor (e.g., public assistance information). Neither a parent, guardian, custodian, nor caretaker can authorize DSS to disclose

162. *See* 10A N.C.A.C. 69, § .0401(f).

163. See the definition of "client" at 10A N.C.A.C. 69, § .0101(1).

164. In all cases, to qualify under the definition of "client" in 10A N.C.A.C. 69, § .0101(1), the guardian must be "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." In other words, to stand in the client's shoes with respect to making decisions about the disclosure of the client's confidential social services information, the guardian must have legal authority to make these types of decisions on the client's behalf.

165. 10A N.C.A.C. 71A, § .0803.

166. *See* Aimee N. Wall, Disclosing Protective Services Information: A Guide for North Carolina Social Services Agencies 39 n.13 (UNC School of Government, 2015) (comparing the language of 10A N.C.A.C. 71A, § .0803 to the language of 10A N.C.A.C. 69, § .0403, which has since been incorporated into 10A N.C.A.C. 69, § .0401(f)).

167. *See* 10A N.C.A.C. 71A, § .0803.

information related to a minor's involvement with CPS, which includes any information about a report of suspected child abuse, neglect, dependency, or death due to maltreatment, as well as any information gathered or generated by DSS about the child following that report.

10 N.C.A.C. 69, § .0401(f) provides that the following persons may consent to the release of a minor client's information:

1. ***The county department of social services, if the client is a minor in the custody of the county department of social services.*** Despite the provision in 10 N.C.A.C. 69, § .0401(f) allowing DSS to authorize the release of information on behalf of a minor in its custody, there are very few scenarios in which DSS could rely solely on this authority to disclose social services information about a minor in DSS custody, due to the limitations of other confidentiality laws.[168] Instead, DSS should generally refer to the provisions of the Juvenile Code (Chapter 7B of the North Carolina General Statutes) to determine when and how DSS can share information about a minor in its custody.
2. ***The minor client or any individual "acting on behalf of the [minor] client in accordance with their right to act on the client's behalf under a legal order, federal or state law."***[169] Assuming this provision does not generally permit an individual acting on behalf of a minor to disclose CPS information governed by the Juvenile Code, then it would only allow disclosures of *other* information that DSS may hold about a minor, such as information about a public assistance case involving the minor.[170] Even in light of that narrowed scope, applying this provision to a minor raises some challenging questions.
    a. ***When may a minor client consent to the disclosure of their own social services information?***
        i. Presumably, any legally emancipated minor could consent to disclosure of their own information, unless they have been declared incompetent or otherwise lack decisional capacity.
        ii. With respect to unemancipated minors, the law is silent. It might be reasonable for DSS to allow an older teenager to consent to the disclosure of their own information, but it would seem unreasonable to allow a young child to sign such a consent form on their own behalf. Each DSS may want to consider creating a policy on this issue, with the understanding that the policy needs to allow for case-by-case determinations regarding the decisional capacity of an older minor.
    b. ***When is someone acting on behalf of a minor "under a legal order, federal or state law"?***
        i. Would this include a parent, acting pursuant to their statutory and constitutional right to exercise supervision, care, and control over their minor child (and by extension, their child's information)?[171] At a minimum, it seems reasonable to

168. One potential scenario in which such a disclosure might be permissible is if DSS has information about the minor that was received prior to DSS receiving a report of abuse, neglect, or dependency regarding the minor. For example, the minor's family may have applied for or received public assistance through DSS (such as Medicaid, Work First, or Food and Nutrition Services) before CPS became involved with the family.

169. *See* 10A N.C.A.C. 69, § .0101(1).

170. Theoretically, a minor with decisional capacity could consent to the disclosure of their own CPS information governed by G.S. Chapter 7B, but a discussion of this complex topic is beyond the scope of this bulletin.

171. *See* G.S. 7B-3400; 7B-100(1); *see also, e.g.*, Troxel v. Granville, 530 U.S. 57 (2000).

assume this would allow a parent to authorize the disclosure of their minor child's information in situations where the parent has applied for or received public assistance on behalf of the minor.[172] However, this definition of someone "acting on behalf of a minor" would not include a biological parent who has relinquished their child for adoption or had their parental rights terminated, nor would it include a foster parent.[173]

Part 3. Weaving Together Legal Requirements for Multiparty Release of Information Forms

Many MDTs involve members who are covered by different confidentiality laws. In some cases, the information held by a single agency or organization may be subject to multiple confidentiality laws. For example, some information held by a single healthcare provider may be subject to HIPAA, G.S. Chapter 122C, and 42 C.F.R. Part 2. If an MDT wants to use a common authorization to release information for the clients it serves, the MDT must draft an ROI form that complies with *all* of the confidentiality laws that apply to its members. This is a complex task that requires careful drafting and guidance from attorneys who are well-versed in these laws.

Although each confidentiality law has its own unique requirements, there are several requirements for disclosures of confidential information made pursuant to a written ROI form that apply across most of the laws discussed in this bulletin, as described below.

Foundational Concepts

- Before disclosing confidential information, an agency or organization must obtain an individual's written authorization for disclosure of that information, unless the use or disclosure of that information is required by court order or otherwise permitted or required by the applicable confidentiality law.
- An individual's decision to sign an ROI form to disclose confidential information must be informed, voluntary, and made by someone with the mental capacity to make decisions about their own information. For more information on these concepts, see Part 1 of this bulletin, "Foundational Principles of Obtaining Client Consent."
- An individual may revoke their ROI form at any time and *must be informed* that they have the right to do so.[174] However, revocation does not apply *retroactively* to information already shared by agencies or organizations that relied on the signed ROI

172. This interpretation would mirror HIPAA, which allows a parent to authorize the disclosure of their unemancipated minor child's protected health information if the parent provided consent to the treatment that is the subject of the disclosure. *See* 45 C.F.R. § 164.502(g)(3)(i).

173. A judge could give any of these parties authority to consent to a disclosure of a minor's information via a court order, but absent such a court order, these parties would not normally have any authority to act on behalf of a minor.

174. There is an exception: North Carolina's communicable disease confidentiality law does not specify that the ROI form must be revocable. However, permitting a client to revoke their consent to the disclosure of communicable disease information is a best practice, and if the entity disclosing communicable disease information is a HIPAA covered entity, then the ROI must be revocable.

form. In other words, an individual's revocation is only effective *prospectively*, meaning it prohibits agencies or organizations from relying on that ROI form to disclose information in the future.

Contents of the ROI Form

An ROI form to disclose confidential information should

- be in writing and be signed and dated by the client whose information may be disclosed (or by another person authorized to sign under applicable confidentiality laws, as described in Part 2 of this bulletin, "Requirements for Client Consent to Release Information Under Federal and State Confidentiality Laws");
- clearly describe, in a specific and meaningful fashion, what types of information about the client may be disclosed;
- list, in a specific and meaningful fashion, purposes for which the client's information may be disclosed;
- list all parties to whom the client's information may be disclosed;
- list all parties that are being given permission to disclose the client's confidential information;
- include a statement about whether treatment, payment, enrollment, or benefits eligibility can be conditioned on the client signing the ROI form (conditioning treatment, payment, enrollment, or benefits eligibility on execution of an authorization is generally prohibited by HIPAA);
- include a specific date or event upon which the form will expire, which may be an actual date (e.g., "January 1, 2030") or an event (e.g., "when Client is no longer receiving services from any member of the ABC 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 it.

Some confidentiality laws also require specific notices to be included in the ROI form when disclosing confidential information.

- **HIPAA** requires an ROI form to include
  - A statement explaining the potential for redisclosure of the individual's PHI, which must put the individual on notice that once their PHI is disclosed in accordance with the authorization, the PHI (1) may no longer be protected by HIPAA if the recipient is not a covered entity or business associate and (2) could be redisclosed by the recipient in accordance with any other applicable law.[175]
  - A statement about remuneration to the HIPAA covered entity, but only if the authorization will permit a HIPAA covered entity to sell the individual's PHI or receive payment for using the individual's PHI for marketing purposes.[176]

175. 45 C.F.R. § 164.508(c)(2)(iii).
176. 45 C.F.R. § 164.508(a)(4).

- **42 C.F.R. Part 2** requires that the ROI form include
  - A statement about the patient's right to elect not to receive any fundraising communications, but only if a Part 2 program intends to use or disclose the patient's records for fundraising purposes on its own behalf.[177]
  - The following, if the patient is consenting to the use or disclosure of their records for treatment, payment, or healthcare operations purposes:
    - a statement about the potential for the records to be redisclosed by the recipient and no longer protected by 42 C.F.R. Part 2 and
    - a statement describing the consequences to the patient of refusing to sign the consent form.[178]
  - A statement that the patient's record (or information contained in the record) may be redisclosed in accordance with the permissions contained in HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. This is only required if a recipient of the information is a HIPAA covered entity or business associate to whom a record (or information in a record) will be disclosed for purposes of treatment, payment, or healthcare operations.[179]

Implementing and Using the ROI Form

- Any agency or organization relying on an ROI form to disclose an individual's confidential information should retain and store a copy of the signed form.[180]
- When an agency or organization obtains or receives an ROI form for the disclosure of confidential information, it must ensure that any disclosures of information it makes are consistent with the terms of the ROI form. Unless otherwise permitted or required by law, an agency or organization cannot go beyond the scope of the ROI form regarding the amount or type of information disclosed, the purposes for which the information may be disclosed, or the parties to whom it may be disclosed. The terms of the ROI form control how much information can be released, the purposes for its release, and the recipients of that information.
- An ROI form to disclose confidential information *permits*, but does not *require*, a covered agency or organization to disclose the information described in the ROI form. However, other state or federal laws may make certain disclosures of confidential information mandatory, with or without the client's consent.[181] For example, one of

177. 42 C.F.R. § 2.31(a)(5)(iii).

178. 42 C.F.R. § 2.31(a)(10).

179. 42 C.F.R. § 2.31(a)(4)(iii).

180. Organizations that are required to comply with HIPAA (covered entities and business associates) must retain authorization forms in accordance with 45 C.F.R. § 164.530(j). Area authorities (LME/MCOs), state facilities, and their contracted providers of MH/DD/SA services must ensure that the ROI is placed in the client record. 10A N.C.A.C. 26B, § .0207.

181. For example, under the state MH/DD/SA confidentiality law, when a client or their legally responsible person requests an MH/DD/SA facility to disclose confidential information to an attorney, disclosure is mandatory. G.S. 122C-53(i). "Legally responsible person," defined at G.S. 122C-3(20), is discussed in Part 2, above, in the "North Carolina's Mental Health, Developmental Disabilities, and Substance Abuse Confidentiality Law" section.

North Carolina's mandatory reporting laws requires any person or institution who has cause to suspect that a juvenile under the age of 18 is abused, neglected, or dependent to make a report to the county department of social services.[182]

Prohibitions Against Combined ROI Forms

In limited circumstances, the use of a combined or "compound" ROI form to share certain types of information is prohibited by law.

- Under HIPAA, an authorization to use or disclose psychotherapy notes can only be combined with another authorization for the use or disclosure of psychotherapy notes. A single ROI cannot authorize the disclosure of psychotherapy notes and protected health information that is not psychotherapy notes.[183]
- Under 42 C.F.R. Part 2, an ROI form for the use or disclosure of SUD counseling notes may only be combined with another written consent for the use or disclosure of SUD counseling notes.[184] An ROI form used to authorize the disclosure of SUD counseling notes cannot also authorize the disclosure of other information that is confidential under 42 C.F.R. Part 2.
- Under 42 C.F.R. Part 2, an ROI form authorizing the use and disclosure of confidential information in a civil, criminal, administrative, or legislative investigation or proceeding cannot be combined with a consent to use and disclose a record for any other purpose.[185]

In these circumstances, the ROI must be narrowly tailored to the specific information or purpose addressed by these respective confidentiality law provisions and cannot exceed their prescribed parameters, either in terms of the purpose or the kind of information disclosed.

Part 4. Best Practices for Using Multiparty ROI Forms in the Multidisciplinary Team Context

Building ROI Forms Around a Shared Mission and Vision

Multiparty ROI forms work best when they are developed and implemented by a group or team (such as an MDT) that shares a common mission and vision for its work. This is because the multiparty ROI form must specify the purposes for which agencies and organizations will share information about a client. The purposes listed on the ROI will be informed by the common mission of the MDT in relation to the people it serves (e.g., protection of a vulnerable adult

182. G.S. 7B-301. In addition to being required by state law, this disclosure of confidential information for the purposes of reporting child abuse or neglect is permitted by the federal confidentiality laws described in this bulletin (HIPAA and 42 C.F.R. Part 2).

183. 45 C.F.R. § 164.508(b)(3)(ii). See 45 C.F.R. § 160.501 for the definition of "psychotherapy notes." *See also* 45 C.F.R. § 164.508(a)(2).

184. 42 C.F.R. § 2.31(b)(2). See 42 C.F.R. § 2.11 for the definition of "substance use disorder (SUD) counseling notes."

185. 42 C.F.R. § 2.31(d).

against abuse and neglect, coordination of care for a substance use disorder patient with complex needs, etc.). The scope of information sharing allowed by the ROI should be consistent with how the MDT intends to serve the individuals who sign it.

It is important to maintain open and honest dialogue among MDT members while collectively drafting an ROI form. Members may have disagreements on issues such as which types of information should or should not be shared under the terms of the ROI, which parties should be included, or whether information shared pursuant to the ROI may be used for certain purposes. The MDT members should come to an agreement on these matters before finalizing and using a multiparty ROI form, since all agencies and organizations listed on the form will be bound by it once it is signed by a client.

Some MDTs may decide to draft and use a memorandum of understanding (MOU) to outline the responsibilities and obligations of all MDT members with respect to how they will use and implement ROI forms in their work with clients. If the terms of an MOU also address how members will use or disclose information about clients served by the MDT, those terms should align with what is allowed by the MDT's ROI form. It is important to remember, however, that an MOU is not a substitute for an ROI form. The ROI, not the MOU, is the legal mechanism that authorizes the use and disclosure of a client's confidential information.

Using ROI Forms

If an MDT decides to develop and use a multiparty ROI form, it is advisable for a single agency, organization, or MDT coordinator to take responsibility for obtaining consent from individuals whose cases are being discussed by the MDT. Under this model, a single agency, organization, or coordinator is responsible for explaining the ROI forms to individuals with the capacity to sign them, providing copies of the forms to the individuals who sign them, storing the signed forms, tracking expiration dates, and communicating with MDT members when a form is revoked or expired.

Using this model may help to streamline the process of working with these forms by creating a centralized "hub" for communication with all MDT members about when individuals have signed forms, when forms have expired, and when forms have been revoked. MDT members must be promptly informed when they can no longer share information pursuant to the ROI because the form has expired or been revoked. This model of centralized responsibility also ensures that individuals signing the ROI forms receive a consistent explanation of the form and how it will be used. However, it is important to remember that MDT members may also have their own individual legal obligations to store ROI forms or document disclosures made using ROI forms, as described in the following section.

Understanding Individual Responsibilities for Storage of Forms and Documentation of Disclosures

Even if a single agency, organization, or individual is responsible for collecting, explaining, and tracking ROI forms for an MDT, each agency, organization, or individual involved in the MDT may also have their own responsibilities under applicable confidentiality laws for storing copies of the form and documenting disclosures.

- ***HIPAA.*** HIPAA covered entities are required to maintain a copy of a signed ROI form for six years from the date of its execution or the date when it last was in effect, whichever is later.[186] HIPAA covered entities are not required to document disclosures made pursuant to a signed ROI.[187]
- ***G.S. Chapter 122C.*** Area authorities, state facilities, and their contracted service providers are required to store a copy of the ROI in the client record.[188]
- ***42 C.F.R. Part 2.*** Each disclosure made with patient consent must be accompanied by a copy of the ROI or a clear explanation of the scope of the ROI.[189]
- ***G.S. 108A-80.*** Social services agencies are required to place a signed copy of the ROI form to disclose confidential social services information in the client's record. When confidential social services information is disclosed pursuant to the client's consent, the DSS director or a delegated representative must document the reason for the disclosure in the client's record.[190]
- There is no storage requirement for ROI forms signed by clients or documentation of redisclosure requirements under North Carolina's communicable disease confidentiality law.

Even for MDT members to whom these legal requirements for maintaining copies of ROI forms and documenting redisclosures do not apply, it is a best practice for each agency or organization involved with the client to keep a copy of the client's ROI in the client's file or record. The provider disclosing information that is confidential under federal or state law—and the individual or entity receiving such information—are bound by the terms of the ROI form with respect to what information may be disclosed, to whom, and for what purpose. The ROI serves as documentation of the disclosing and receiving entities' obligations to the client regarding their use and disclosure of the client's confidential information.

Explaining ROI Forms to Clients

An individual explaining the ROI form to a client served by the MDT must feel confident that the client has the mental capability to understand what they are being asked to sign and how it will impact the use and disclosure of their confidential information by the MDT. The client must be making a *voluntary* decision to sign the ROI form. The client needs to make the best decision for the client, not what anyone else thinks is the best decision for the client. The person explaining the ROI form to the client should give the client all the information they need to make the judgment call on their own.

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186. 45 C.F.R. § 164.508(b)(6); *id.* § 164.530(j).
187. 45 C.F.R. § 164.528(a)(1)(iv).
188. 10A N.C.A.C. 26B, § .0207.
189. 42 C.F.R. § 2.32(b).
190. 10A N.C.A.C. 69, § .0401(i).

A client needs to understand that treatment and eligibility for insurance coverage or benefits is not conditioned on them signing the ROI form. This is an important point to clarify with an individual who is considering signing an ROI. An individual might be asked to sign lots of different forms in the process of receiving treatment and services from different providers. That individual might incorrectly assume that they are required to sign the ROI form in order to receive treatment or services from a provider in the MDT. The individual explaining the ROI form to the client needs to explain that the client may still receive treatment, services, benefits, and/or insurance coverage (if applicable) from organizations in the MDT even if the client decides not to sign the ROI. If there is a service that is contingent on the client signing the ROI form (for example, receiving coordinated care or case review from the MDT), that should be explained to the client as well.

The client or other individual legally authorized to sign the ROI also needs to understand that they have the power to revoke their authorization at any time. The ROI form must include a revocation page for this purpose (though the client must be allowed to revoke the authorization orally as well). Finally, the individual signing the ROI form should also be given a copy of the document after they sign it.

Updating Forms to Reflect Organizational Changes

Sometimes, an MDT's standard ROI form must be updated to reflect changes within the MDT itself. For example, new members from different organizations or agencies may join the MDT, while others might leave. Or the MDT's members may collectively decide to limit or expand the scope of information sharing permitted by the ROI form (such as adding or redacting certain purposes for which MDT members may share information about a client). Changes in relevant confidentiality laws that apply to the MDT's members may also necessitate updates to the form.

In addition to reflecting these changes in the ROI form used for *new* clients, the MDT should present individuals who are *already* being actively served by the MDT with an updated copy of the form, explain the changes to the form, and ask them to sign the new form.

An updated ROI form does not allow an MDT to make any changes to its information-sharing practices until the new form is signed by the individual whose information is being shared (or an individual legally authorized to sign on their behalf). For example, an MDT might decide to add new organizations or agencies to its membership after a client has already signed an ROI form, but until those organizations or agencies are reflected in a new ROI form signed by the client, other MDT members cannot rely on the first ROI form to share confidential information with those organizations or agencies.

Training for MDT Members

It can be challenging to understand how and when information can be shared pursuant to an ROI form. If an MDT decides to create and use an ROI form, the MDT coordinator or leader should arrange or conduct training for MDT members on how to understand and implement the ROI form.

Among other things, such training should:

- **Ensure that each MDT member can explain the ROI form to a client/patient.** Even if one organization or agency within the MDT is generally responsible for explaining the ROI form to clients, every member of the MDT should be prepared to answer

questions about the form that might arise from individuals served by the MDT. MDT members should understand that a client's decision to sign the ROI form must be informed, voluntary, and made by someone with the capacity to consent.

- **Explain that the ROI form does not allow MDT members to redisclose information to anyone not listed on the form.** The ROI form operates like a closed loop. MDT members can only redisclose confidential information to other agencies and organizations listed on the form for the purposes allowed by it. They cannot *redisclose* information to third-party individuals or entities not listed on the ROI. An MDT member would need a separate client consent—or a specific exception under an applicable confidentiality law—in order to redisclose information to a third-party individual or entity that is not listed as a permitted recipient of information on the ROI form.

  For example, if MDT members need to be able to disclose confidential information in a court proceeding, the ROI needs to explicitly state that the client's information may be disclosed to a court. Unless the ROI permits that disclosure to the court, such disclosure would be prohibited except as otherwise allowed by law. Further, when dealing with SUD information protected by 42 C.F.R. Part 2, a consent to use and disclose records in civil, criminal, administrative, or legislative proceedings cannot be combined with a consent to use or disclose records for any other purpose.[191] Thus, an ROI to disclose SUD information and other types of confidential information within an MDT for the purposes of coordinating treatment and other services for the client cannot contain permission to disclose or redisclose such information in the context of court proceedings.
- **Provide concrete guidance about what types of confidential information (if any) *cannot* be disclosed pursuant to the ROI.** It is common for people to think of an ROI form as a "magic key" that unlocks access to sharing all confidential information. However, as described in Part 2 of this bulletin, there are limitations to what information can be disclosed under each confidentiality law, even pursuant to client consent. These limitations are most acute if an MDT involves representatives from a county department of social services, since certain types of social services information (such as child welfare information) may not be disclosed pursuant to a client's consent.
- **Allow MDT members to test and practice their knowledge by discussing hypothetical case studies.** Training on how to use the ROI form should include some hypothetical scenarios based on the type of individuals served by the MDT and the type of information shared by members of the MDT. For example, MDT members could practice working through scenarios involving information they would not be allowed to share pursuant to the ROI form or involving third parties to whom they could not disclose information.

191. 42 C.F.R. § 2.31(d).

Conclusion

MDTs are an increasingly common approach to providing integrated, multifaceted support to a single individual in the context of service provision, case investigation, medical treatment, and more. Taking a multidisciplinary approach often requires sharing an individual client's information between different community partners, which can be a daunting task given the complex web of state and federal confidentiality laws that may apply to different MDT members and the information they hold. Nevertheless, in many instances, a client's information can be shared between MDT members with the client's informed, written consent. Weaving together the requirements of applicable confidentiality laws to create a multiparty ROI form can aid MDTs and the clients they serve by reducing the administrative burden associated with having clients sign numerous forms. The use of a multiparty ROI form may also make it easier for clients to understand what information is being shared, with whom, and for what purposes.

Further Reading

For an example of a multiparty ROI and MOU developed for an MDT context, see "Part 4: Sample Policies and Procedures" of the *Adult Protection Multidisciplinary Team Toolkit*, available at https://protectadults.sog.unc.edu/mdt-toolkit/. Another example of a multiparty ROI and MOU may be found on the Substance Use Network Project "Resources" page, at https://sun.sog.unc.edu/resources/.