**Request Your Records**

All information contained in the Silver Hill Hospital medical record is confidential and protected by Federal Law under the Health Insurance Portability and Accountability Act (HIPAA).

An original properly completed HIPAA authorization form is required prior to the release of any information (exceptions per HIPAA regulation).

All authorizations must be signed by the patient or legal representative.

Requirements to sign an authorization for release of medical records:

- Patient - must be competent and of legal age of 16 or older
- Minor patients - signed authorization by legal guardian or custodial parent
- Deceased patients - signed authorization by Executor of the Estate with copy of court papers granting conservatorship
- Conservator - signed authorization by conservator with copy of court papers granting conservatorship

**Fee:**
No charge for copies of 15 pages or less, 16 pages or more are $.65 per page. No charge for copies sent directly to physicians, hospitals, therapists or social service agencies.

All requests for medical record information are completed by the Health Information Management Department (HIM).

**Contact Information:**
Silver Hill Hospital
HIM Department
208 Valley Road
New Canaan, CT 06840
O: 203 801.2250
F: 203 972.3470

**SILVER HILL HOSPITAL**
**208 Valley Road**
**New Canaan CT 06840**
**(203) 966-3561**

# PATIENT AUTHORIZATION

***Please Read Carefully***

Patient Name Acct#

**Patient Name**: ______________________________ **Date of Birth**: ____________________

I, ______________________________ (Name of individual giving Authorization) hereby authorize SILVER HILL HOSPITAL to release pertinent information with respect to the treatment of the above-referenced patient, including information relating to diagnosis and/or treatment of mental illness, drug or alcohol abuse and/or confidential HIV/HBV related information and to make uses and disclosures of my protected health information as follows:

**1. Description of the Information to be used or disclosed. (Describe the information using plain language. Be specific.)**

______________________________

______________________________

______________________________

**2. The Name of Person or Organization who is to receive this information. (**Include address, phone number, fax, email)

______________________________

______________________________

______________________________

Please select one:

[ ] I authorize Silver Hill Hospital to **email my confidential information to: ____________________(email addr)**

[ ] I authorize Silver Hill Hospital to **copy my confidential information onto electronic media (CD / USB drive).**

[ ] I authorize Silver Hill Hospital to **mail a paper copy of my confidential information to Person/Organization identified**

**3. Purpose(s) of the use or disclosure.** (Check below the reason(s) for requesting this information)

**[ ] Continuing Care** **[ ] Legal** ______________________________

**[ ] Insurance** **[ ] Family Involvement** ______________________________

**[ ] Personal Use** **[ ] Other, Please specify** ______________________________

**4. Expiration Date or Event** This Authorization will expire in 6 months

**5. Revocation**

I understand that I may revoke this Authorization at any time by providing written notice to SILVER HILL HOSPITAL. I understand that I may not be able to revoke this Authorization if SILVER HILL HOSPITAL has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

**6. Services Not Conditioned on Authorization**

I understand that SILVER HILL HOSPITAL will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

**7. Redisclosure**

I understand that the protected health information disclosed under this Authorization may be subject to redisclosure by the recipient and no longer protected by the federal Privacy Regulations. I also understand that if the PHI that is disclosed under this Authorization is confidential psychiatric, drug/alcohol abuse or HIV/AIDS related information, the recipient may not redisclose that information without authorization or as otherwise permitted under state and federal law. "

**8. Acknowledgement**

I acknowledge that I have carefully reviewed this Authorization and understand its provisions. A copy of this executed agreement will be given to me.

____________________ ______________________________

Witness Date Signature of person giving Authorization and relationship to patient, if applicable

Telephone number: ____________________

**SILVER HILL HOSPITAL**
**208 Valley Road**
**New Canaan CT 06840**
**(203) 966-3561** **FAX: 203-972-3470**

## NOTICE

### Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

> The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

### Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

### HIV/HBV Related Information

In the event information released constitutes confidential HIV/HBV related information protected under Connecticut law:

> This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

### Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by Silver Hill Hospital is protected by Federal law and regulations. Generally, Silver Hill Hospital may not say to a person outside Silver Hill Hospital that a patient attends Silver Hill Hospital, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

(1) The patient consents in writing.
(2) The disclosure is allowed by a court order, or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by Silver Hill Hospital is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at Silver Hill Hospital or against any person who works for Silver Hill Hospital or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.