Name: ____________________

Date of Birth: ____-____-______

MRN: ____________________

Designation of Personal Representative
(For Dartmouth-Hitchcock Pharmacy Only)

I hereby designate the following Personal Representative to assist me in exercising my health Information rights under the New Hampshire Patients' Bill of Rights (NH RSA 151:19-21, X) and the Federal Privacy Rule (45 CFR §165.502(g)), as indicated below.

My designated Personal Representative is:

Name: ____

Address: ____

Phone: ____

I request that my personal representative be allowed to assist me in exercising the following Rights related to my protected health information (**please check applicable items**):

___I request that my personal representative be allowed to discuss my prescriptions, insurance information, prescription history, conditions, allergies and any other pertinent information with any and all D-H Pharmacy staff

___The right to access and obtain a copy of my medical records and other pertinent information

___No expiration

___Expires on ___/___/___

____ ____________________

Patient's Name Date

_______________________________ ___________________________________

Signature of Patient or Legal Guardian's Name if Applicable (please include documentation)

I understand that if I no longer wish for this Personal Representative designation to be in effect, I must revoke the designation in writing to Dartmouth-Hitchcock Medical Center, Dartmouth-Hitchcock Pharmacy, One Medical Center Drive, Lebanon, NH 03756. I also understand that it is my responsibility to notify my designee that I have revoked his or her access to my protected health information