Dartmouth-Hitchcock Designation of Personal Representative	MRN: Name: DOB:

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patients' Bill of Rights and the federal HIPAA Privacy Rule, as indicated below:

Name_____ Relationship_____

Address_____ Phone Number_____

Verbal Conversations:

I permit Dartmouth-Hitchcock (comprised of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinics) and Cheshire Medical Center staff to discuss my protected health information, in person or by telephone, with the person named above. This includes the ability to make, cancel, or reschedule appointments on my behalf and assist me in making payments or inquiring about my billing account.

Other:

In addition, I grant my Personal Representative the following:

- ❑ Proxy access to my "myD-H" patient portal account;
- ❑ The ability to request or receive paper or electronic copies of my medical records;
- ❑ The ability to authorize the use or disclosure of my protected health information;
- ❑ If my Personal Representative is an employee of Dartmouth-Hitchcock or Cheshire Medical Center, the ability to access my entire medical record electronically.

I understand and acknowledge that the protected health information I am authorizing Dartmouth-Hitchcock and Cheshire Medical Center to share with my Personal Representative may contain drug/alcohol use, mental health, HIV, and/or genetic testing information.

I understand and acknowledge that this designation applies to all clinical areas of Dartmouth-Hitchcock and Cheshire Medical Center.

This authorization shall remain in effect until I send a written request to revoke this designee as my Personal Representative, to Dartmouth-Hitchcock and/or Cheshire Medical Center Health Information Services.

_____ _____

Patient's Name Date

_____ _____

Signature of Patient or Legal Representative Legal Representative's Name (if applicable)