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 (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR § 164.502(g)), as indicated below.

My designated Personal Representative is: Relationship: _____

Name: _____

Address: _____

Phone: _____

I request that my personal representative be allowed to assist me in exercising the following rights related to my protected heath information. I understand and acknowledge that my protected health information may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information. (**please check all applicable items**):

- ❑ The right to access and obtain a copy of my medical records and other protected health information;
- ❑ The right to authorize use or disclosure of my protected health information;
- ❑ The right to request an amendment of any protected health information;
- ❑ The right to request an accounting of disclosures of my protected health information;
- ❑ The right to communicate verbally regarding my appointments;
- ❑ The right to have verbal communication with my health care team;
- ❑ The right to request a myD-H Patient Portal Proxy Access;
- ❑ Other (please specify): _____

  _____

- ❑ No expiration
- ❑ Expires on _____ (date)

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. 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.

_____ _____

Patient's Name Date

_____ _____

Signature of Patient or Legal Guardian Legal Guardian's Name if Applicable