Alice Peck Day Memorial Hospital

Personal Representative Designation

Name:

MR#: place patient sticker here

DOB:

I 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 (45CFR 164.502(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. I understand and acknowledge that my protected health information may contain drug/alcohol, mental health, HIV and or/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;

Other (please specify):

_____

_____

☐ No expiration (Designation ends upon the death of the patient)
Expires on _____ (date or event)

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 Alice Peck Day Memorial Hospital – Health Information Mgmt. Dept. 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 Name **(Print)** Date

_____ _____

Signature of Patient/Legal Guardian Legal Guardian's Name if applicable **(Print)**

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