

## **Designation of Personal Representative Minor Child**

MRN (optional):
Patient Name:
Date of Birth:
Two identifiers needed or Patient Lahel

I hereby designate the following Personal Representative to assist my child in exercising their health information rights under

the Ne	w Hampshire Patients' Bill of Rights and t	the federal HIP	AA Privacy Rule, as in	dicated below:
Name		R	elationship	Date of Birth:
Addres	ss	P	hone Number	
Verbal	Conversations:			
Clinics Health protect	it the staff at Dartmouth Hitchcock (com.), Cheshire Medical Center, Alice Peck E Center (NLH), Hanover Psychiatry (HP), ted health information, in person or by te, or reschedule appointments on my child ht.	Day Memorial H and Visiting Nu elephone, with t	ospital (APD) and Ne rse and Hospice for V he person named abo	w London Hospital, including Newport T and NH (VNH), to discuss my child's ove. This includes the ability to make,
Other:				
In addi	tion, I grant my child's Personal Represei	ntative the follow	wing:	
	Proxy access to my child's "myDH" pat	ient portal acco	unt;	
	The ability to request or receive paper	or electronic co	pies of my child's med	lical records;
	The ability to authorize the use or discl	osure of my chi	ld's protected health in	nformation;
Center	estand and acknowledge that the protected, APD, NLH HP, or VNH, to share with melling the HIV, and/or genetic testing information.			
	nderstand and acknowledge that this design, APD, NLH, HP, and VNH.	gnation applies t	to all clinical areas of D	Partmouth Hitchcock, Cheshire Medical
inform appoir by the	non-custodial person to be granted attion of a minor child, <u>BOTH</u> legal parentment of the above-named designee.  Court, that documentation must be onation of a personal representative for	ents (if applica If custodial an I file with Dartr	ble) of the minor chil d parental rights and nouth Health at or pr	d must sign this form approving the I responsibilities have been granted ior to the signing of this form or the
	uthorization shall remain in effect until I/we			
Center	, APD, NLH, HP or VNH Health Information	on Services. Su	bmitting a new form w	rill revoke an existing form.
Signati	ure of Parent or Guardian	Date	Printed Name	Relationship
Signati	ure of Parent or Guardian	Date	Printed Name	Relationship
"Dartmo	uth Health (DH)" is the corporate parent of the covere	ed entities listed belo	w, each of which is an indiv	dual corporate entity legally separate and distinct

from Dartmouth Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and Dartmouth Hitchcock Clinic, operating jointly as "Dartmouth Health," Mt. Ascutney Hospital and Health Center, New London Hospital, Hanover Psychiatry and Visiting Nurses and Hospice for VT and NH. The DH ACE is comprised only of DH members who are currently using a single, integrated electronic medical record system, referred to sometimes as "eDH."

SAMPLE:

M Dartmouth	MRN (optional):	
Health	Patient Name	Tabitha Smith
not the second	Date of Birth:	2/20/2015
Designation of Personal Representative Minor Child		
hereby designate the following Personal Representa the New Hampshire Patients' Bill of Rights and the fe		
Name Brench Smith	Relationship Gra	ndmother Date of Birth: 1/12/196
Address I Welcome Lane, City, St	Phone Number	603-000-0000
Verbal Conversations:		
protected health information, in person or by telepho cancel, or reschedule appointments on my child's bel account		
Other:		
in addition, I grant my child's Personal Representative	e the following:	
In addition, I grant my child's Personal Representativ  Proxy access to my child's "myDH" patient p		
The second secon	portal account;	medical records.
Proxy access to my child's "myDH" patient p	portal account; ectronic copies of my child's	on perferringen periode
Proxy access to my child's "myDH" patient p  The ability to request or receive paper or ele	portal account; ectronic copies of my child's e of my child's protected hea ath information I am authoriz	ith information; ing Dartmouth Hitchcock, Cheshire Medical
Proxy access to my child's "myDH" patient p  The ability to request or receive paper or ele  The ability to authorize the use or disclosure understand and acknowledge that the protected heal	portal account; ectronic copies of my child's a of my child's protected hea atth information I am authoriz ild's Personal Representation	ilth information; ing Dartmouth Hitchcock, Cheshire Medical e may contain drug/alcohol abuse, mental
Proxy access to my child's "myDH" patient p The ability to request or receive paper or ele The ability to authorize the use or disclosure understand and acknowledge that the protected hea Center, APD, NLH HP, or VNH, to share with my chi nealth, HIV, and/or genetic testing information.  We understand and acknowledge that this designation Center, APD, NLH, HP, and VNH.  For a non-custodial person to be granted the r information of a minor child, BOTH legal parents ( appointment of the above-named designee. If cut the Court, that documentation must be on file to the Court, that documentation must be on file	portal account; ectronic copies of my child's a of my child's protected hea ath information I am authoriz ild's Personal Representation on applies to all clinical areas rights and permissions in (if applicable) of the minor stodial and parental rights with Dartmouth Health at	Ith information:  ing Dartmouth Hitchcock, Cheshire Medical e may contain drug/alcohol abuse, mental of Dartmouth Hitchcock, Cheshire Medical fentified above to the protected health child must sign this form approving the and responsibilities have been granted or prior to the signing of this form or the
Proxy access to my child's "myDH" patient p  The ability to request or receive paper or ele  The ability to authorize the use or disclosure understand and acknowledge that the protected heal center, APD, NLH HP, or VNH, to share with my chi realth, HIV, and/or genetic testing information.  We understand and acknowledge that this designation center, APD, NLH, HP, and VNH.  For a non-custodial person to be granted the r information of a minor child, BOTH legal parents ( appointment of the above-named designee. If cur by the Court, that documentation must be on file in designation of a personal representative for the more this authorization shall remain in effect until I/we sent	portal account; ectronic copies of my child's a of my child's protected hea ath information I am authoriz ild's Personal Representation applies to all clinical areas rights and permissions ic (if applicable) of the minor standal and parental rights with Dartmouth Health at ninor child cannot be con- d a written request to revoke	ith information:  Ing Dartmouth Hitchcock, Cheshire Medical e may contain drug/alcohol abuse, mental  of Dartmouth Hitchcock, Cheshire Medical fentified above to the protected health child must sign this form approving the and responsibilities have been granted or prior to the signing of this form or the reyed.  to Dartmouth Hitchcock, Cheshire Medical
Proxy access to my child's "myDH" patient p The ability to request or receive paper or ele The ability to authorize the use or disclosure understand and acknowledge that the protected hea Center, APD, NLH HP, or VNH, to share with my chi health, HIV, and/or genetic testing information.  I/we understand and acknowledge that this designation Center, APD, NLH, HP, and VNH.  For a non-custodial person to be granted the r information of a minor child, BOTH legal parents ( appointment of the above-named designee. If cut by the Court, that documentation must be on file of designation of a personal representative for the m This authorization shall remain in effect until I/we sent Center, APD, NLH, HP or VNH Health Information Se  Signature of Parent or Guardian	portal account; ectronic copies of my child's a of my child's protected hea ath information I am authoriz ild's Personal Representation applies to all clinical areas rights and permissions ic (if applicable) of the minor standal and parental rights with Dartmouth Health at ninor child cannot be con- d a written request to revoke	ith information:  Ing Dartmouth Hitchcock, Cheshire Medical e may contain drug/alcohol abuse, mental  of Dartmouth Hitchcock, Cheshire Medical fentified above to the protected health child must sign this form approving the land responsibilities have been granted for prior to the signing of this form or the reyed.  It o Dartmouth Hitchcock, Cheshire Medical orn will revoke an existing form.
Proxy access to my child's "myDH" patient p The ability to request or receive paper or ele The ability to authorize the use or disclosure understand and acknowledge that the protected heat Center, APD, NLH HP, or VNH, to share with my chi- nealth, HIV, and/or genetic testing information.  We understand and acknowledge that this designation Center, APD, NLH, HP, and VNH.  For a non-custodial person to be granted the r information of a minor child, BOTH legal parents ( appointment of the above-named designee. If cut by the Court, that documentation must be on file designation of a personal representative for the m This authorization shall remain in effect until I/we sent Center, APD, NLH, HP or VNH Health Information Se	portal account; ectronic copies of my child's a of my child's protected hea ath information I am authoriz ild's Personal Representation applies to all clinical areas rights and permissions ic (if applicable) of the minor with Dartmouth Health at ninor child cannot be com d a written request to revoke ervices. Submitting a new for	ith information:  Ing Dartmouth Hitchcock, Cheshire Medical e may contain drug/alcohol abuse, mental  of Dartmouth Hitchcock, Cheshire Medical fentified above to the protected health child must sign this form approving the land responsibilities have been granted for prior to the signing of this form or the reyed.  It o Dartmouth Hitchcock, Cheshire Medical orn will revoke an existing form.

EFMC Approvat. 4/14/2022

Returning your Designation of Personal Representative Form For

## myDH Portal Access - Send form to myDH@hitchcock.org ☐ Cheshire Medical Center ☐ Alice Peck Day Health Information Services HIM Department 590 Court Street

10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 650-7110 Fax: (603) 640-1970 Email: medicalrecords@apdmh.org

Ph: (603) 354-5477 Fax: (603) 676-4253 Email: cmcroi@cheshire-med.com

Keene, NH 03431

Health Information Services Approval: 9/19/2024 Scan to: Personal Representative

Health Information Services 273 County Road New London, NH 03257

Release of Information 11 John Stark Highway Newport, NH 03773 Ph:\_(603) 865-2855

Health Information Services

1 Medical Center Drive

Lebanon, NH 03756

Ph: (603) 650-7110

Fax: (603) 727-7406

Center

☐ Dartmouth Hitchcock Medical Center

Email: Lebanon.Release.of.Information@hitchcock.org

☐ Newport Health Fax: (603) 863-3585 23 S. Main St., Suite 2B Hanover, NH 03755 Ph: (603) 277-9110 Fax: (603) 277-9154

☐ Hanover Psychiatry

☐ Visiting Nurse and Hospice for VT/NH Health Information Services

1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7406 Email:

Lebanon.Release.of.Information@hitchcock.org

☐ Manchester, Nashua & Concord - DH Health Information Services 100 Hitchcock Way Manchester, NH 03104

Ph: (603) 695-2820

Fax: (603) 727-7828 Email: DH-ROI@hitchcock.org ☐ New London Hospital

Ph: (603) 526-5247 Fax: (603) 526-5051 Email:

NLHMedicalRecords@NewLondonHospital.org