Dartmouth Health **Designation of Personal Representative Minor Child**	MRN: NAME: DOB: Two identifiers needed or Patient Label

I hereby designate the following Personal Representative to assist my child in exercising their 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 the staff at Dartmouth Hitchcock (comprised of Dartmouth Hitchcock Medical Center and Dartmouth Hitchcock Clinics), Cheshire Medical Center, Alice Peck Day Memorial Hospital (APD) and New London Hospital, including Newport Health Center (NLH), Hanover Psychiatry (HP), and Visiting Nurse and Hospice for VT and NH (VNH), to discuss my child's 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 child's behalf and assist in making payments or inquiring about my child's billing account.

Other:

In addition, I grant my child's Personal Representative the following:

- ❑ Proxy access to my child's "myDH" patient portal account;
- ❑ The ability to request or receive paper or electronic copies of my child's medical records;
- ❑ The ability to authorize the use or disclosure of my child's protected health information;

I understand and acknowledge that the protected health information I am authorizing Dartmouth Hitchcock, Cheshire Medical Center, APD, NLH HP, or VNH, to share with my child's Personal Representative may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information.

I/we understand and acknowledge that this designation applies to all clinical areas of Dartmouth Hitchcock, Cheshire Medical Center, APD, NLH, HP, and VNH.

For a non-custodial person to be granted the rights and permissions identified above to the protected health information of a minor child, <u>both</u> legal parents (if applicable) of the minor child must sign this form approving the appointment of the above-named designee. If custodial and parental rights and responsibilities have been granted by the Court, that documentation must be on file with Dartmouth Health at or prior to the signing of this form or the designation of a personal representative for the minor child cannot be conveyed.

This authorization shall remain in effect until I/we send a written request to revoke to Dartmouth Hitchcock, Cheshire Medical Center, APD, NLH, HP or VNH Health Information Services. Submitting a new form will revoke an existing form.

_____

Signature of Parent or Guardian Date Printed Name Relationship

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Signature of Parent or Guardian Date Printed Name Relationship

The following organizations are members of Dartmouth Health System: Alice Peck Day Memorial Hospital; Cheshire Medical Center; Dartmouth Hitchcock Clinic and Mary Hitchcock Memorial Hospital (operating jointly as "Dartmouth Hitchcock Medical Center"); Hanover Psychiatry; Mt. Ascutney Hospital and Health Center; New London Hospital; and Visiting Nurse and Hospice of Vermont and New Hampshire.

Health Information Services Approval: 4/13/2022 EFMC Approval: 10/13/2022 Scan to: Designated Personal Representative