Dartmouth Health **Designación de representante personal**	MRN (opcional):_____ Nombre del paciente: _____ Fecha de nacimiento: _____ Se necesitan dos identificadores o la

Por la presente designo al siguiente representante personal para que me ayude a ejercer mis derechos de información de salud bajo la Declaración de derechos de los pacientes de New Hampshire y la ley federal HIPAA sobre privacidad (Ley de Transferencia y Responsabilidad de los Seguros de Salud), como se indica a continuación:

Nombre _____ Relación _____ Fecha de nacimiento: _____

Dirección _____ Número de teléfono _____

Conversaciones verbales:

Autorizo al personal de Dartmouth Health compuesto por: Alice Peck Day Memorial Hospital (APD), Cheshire Medical Center, Dartmouth Health Home Care (DHHC), Dartmouth Hitchcock Medical Center (DHMC) y Dartmouth Hitchcock Clinics (DHC), Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney Hospital y Health Center (Mt. Ascutney), New London Hospital, incluido Newport Health Center (NLH), y Valley Regional Hospital (VRH), a comentar mi información protegida de salud, en persona o por teléfono, con la persona mencionada arriba. Esto incluye la capacidad de concertar, cancelar o reprogramar citas en mi nombre y ayudarme a hacer pagos o consultas sobre mi cuenta de facturación.

Otro:

Asimismo, le otorgo lo siguiente a mi representante personal:

- ❑ Acceso de apoderado a mi cuenta del portal de pacientes “myDH”;
- ❑ Acceso UNICAMENTE a la facturación de mi cuenta del portal de pacientes “myDH”;
- ❑ Capacidad de solicitar o recibir copias electrónicas o impresas de mis registros médicos;
- ❑ Capacidad de autorizar, usar o revelar mi información protegida de salud;

Entiendo y reconozco que la información protegida de salud que autorizo a Dartmouth Health: APD, Cheshire Medical Center, DHHC, DHMC, DHC, Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney, NLH o VRH a compartir con mi Representante Personal puede incluir información sobre consumo de drogas/alcohol, salud mental, VIH o pruebas genéticas.

Comprendo y acepto que esta designación se aplica a todas las áreas clínicas de Dartmouth Health.

La presente autorización tendrá vigencia hasta que yo solicite la revocación por escrito a Dartmouth Health. Presentar un nuevo formulario anulará un formulario existente.

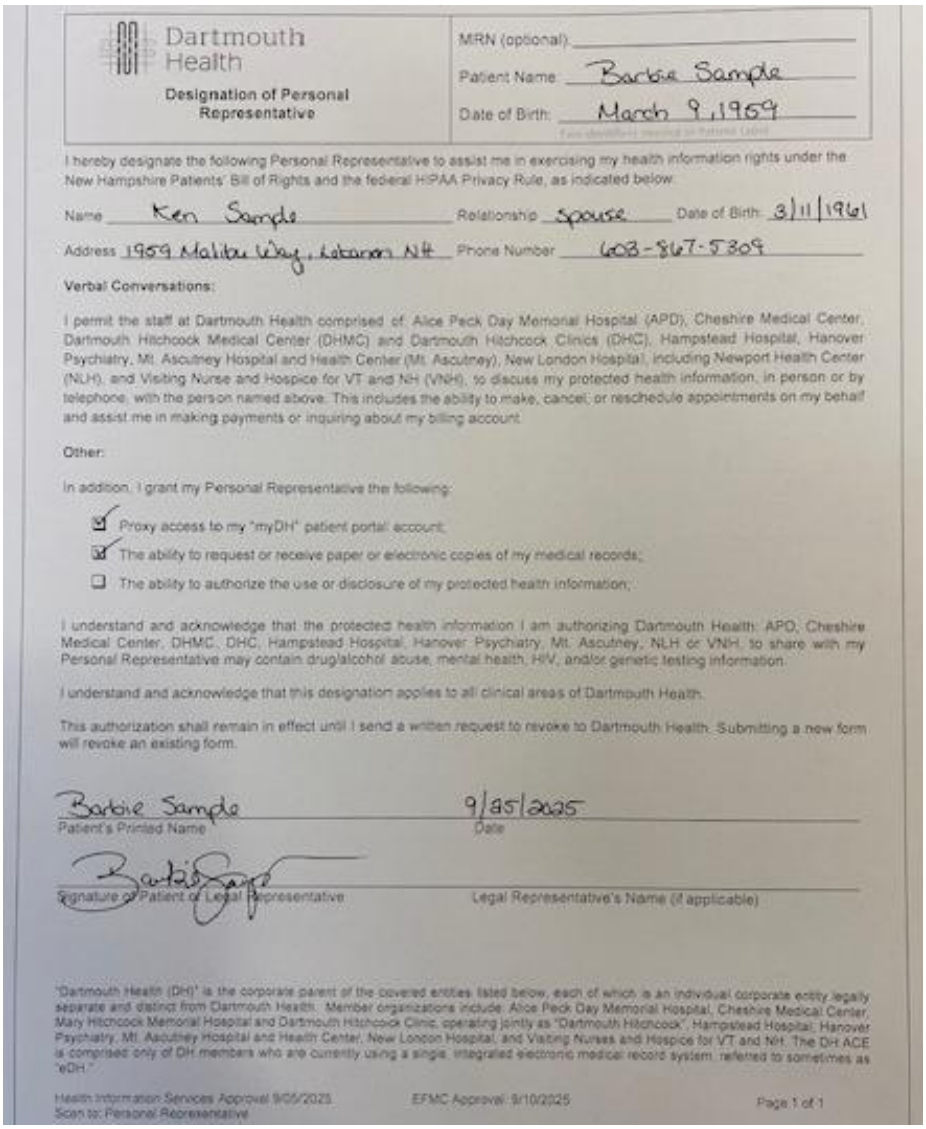
_____

Nombre impreso del paciente Fecha

_____

“Dartmouth Health (DH)” es la institución matriz de las entidades cubiertas que se indican a continuación, cada una de las cuales es una entidad corporativa individual legalmente separada y distinta de Dartmouth Health. Entre las organizaciones que son miembros, están las siguientes: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Dartmouth Health Home Care, Mary Hitchcock Memorial Hospital y Dartmouth Hitchcock Clinic, que operan conjuntamente como “Dartmouth Hitchcock”, Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney Hospital and Health Center, New London Hospital, y Valley Regional Hospital. Las ACE de DH están compuestas solo por miembros de DH que actualmente utilizan un sistema de registro médico electrónico único e integrado, a veces denominado “eDH”.

Firma del paciente o del representante legal Nombre del representante legal (si corresponde)



Dartmouth Health

Designation of Personal Representative

MRN (optional): _____

Patient Name: Barbie Sample

Date of Birth: March 9, 1959

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: Ken Sample Relationship: Spouse Date of Birth: 3/11/1961

Address: 1959 Malibu Way, Lebanon NH Phone Number: 608-867-5309

Verbal Conversations:

I permit the staff at Dartmouth Health comprised of: Alice Peck Day Memorial Hospital (APD), Cheshire Medical Center, Dartmouth Hitchcock Medical Center (DHMC) and Dartmouth Hitchcock Clinics (DHC), Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney Hospital and Health Center (Mt. Ascutney), New London Hospital, including Newport Health Center (NLH), and Visiting Nurse and Hospice for VT and NH (VNH), 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 "myDH" 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;

I understand and acknowledge that the protected health information I am authorizing Dartmouth Health: APD, Cheshire Medical Center, DHMC, DHC, Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney, NLH or VNH, to share with my Personal Representative may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information.

I understand and acknowledge that this designation applies to all clinical areas of Dartmouth Health.

This authorization shall remain in effect until I send a written request to revoke to Dartmouth Health. Submitting a new form will revoke an existing form.

Barbie Sample 9/25/2025

Patient's Printed Name Date

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

"Dartmouth Health (DH)" is the corporate parent of the covered entities listed below, each of which is an individual 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 Hitchcock", Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney Hospital and Health Center, New London Hospital, 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."

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Scan to: Personal Representative

Devolución de su Formulario de Designación de Representante Personal para el acceso al portal myDH – Enviar el formulario a: myDH@hitchcock.org

- ❑ **Alice Peck Day**, HIS Dept., 10 Alice Peck Day Drive, Lebanon, NH 03766, Tel.: 603-650-7110, Fax: 603-640-1970
  Correo electrónico: *medicalrecord@apdmh.org*
- ❑ **Cheshire Medical Center**, HIM Dept., 590 Court Street, Keene, NH 03431, Tel.: 603-354-5477, Fax: 603-676-4253
  Correo electrónico: *cmcroi@cheshire-med.com*
- ❑ **Dartmouth Health Home Care**, HIS Dept., 1 Medical Center Drive, Lebanon, NH 03756, Tel.: 603-650-7110,
  Fax: 603-727-7406 Correo electrónico: *HIS@hitchcock.org*
- ❑ **Dartmouth Hitchcock Medical Center**, HIS Dept., 1 Medical Center Drive, Lebanon NH 03756, Tel.: 603-650-7110, Fax: 603-727-7406
  Correo electrónico: *HIS@hitchcock.org*
- ❑ **Hampstead Hospital**, HIM Dept., 218 East Road, Hampstead, NH 03841, Tel.: 603-329-5311, Fax: 603-329-9460
- ❑ **Hanover Psychiatry**, 23 S. Main Street, Suite 2B, Hanover, NH 03755, Tel: 603-277-9110, Fax: 603-277-9154
- ❑ **DH Manchester, Nashua & Concord**, HIS Dept., 100 Hitchcock Way, Manchester, NH 03104, Tel.: 603-695-2820, Fax: 603-727-7828
  Correo electrónico: *DH-ROI@hitchcock.org*
- ❑ **Mt. Ascutney Hospital and Health Center**, HIM Dept., 289 County Road, Windsor, VT 05089, Tel.: 802-674-6711, Fax: 603-727-7904
  Correo electrónico: *HIM@mahhc.org*
- ❑ **New London Hospital**, HIS Dept., 273 County Road, New London, NH 03257, Tel.: 603-526-5247, Fax: 603-526-5051
  Correo electrónico: *NLHMedicalRecords@NewLondonHospital.org*
- ❑ **Newport Health Center**, ROI Dept., 11 John Stark Highway, Newport, NH 03773, Tel.: 603-865-2855, Fax: 603-863-3585

❑ **Valley Regional Hospital**, HIS Dept., 253 Elm Street, Claremont, NH 03743, Ph: 603-542-1831, Fax: 603-542-1815
Correo electrónico: healthinfo@vrh.org