Dartmouth Health **Designation of Personal Representative Minor Child**	MRN (optional): _____ Patient Name: _____ Date of Birth: _____ 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 _____ Date of Birth: _____

Address _____ Phone Number _____

Verbal Conversations:

I permit the staff at Dartmouth Health comprised of: Alice Peck Day Memorial Hospital (APD), Cheshire Medical Center, Dartmouth Health Home Care (DHHC), 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 Valley Regional Hospital (VRH), 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:

- ❑ Full Proxy access to my child's "myDH" patient portal account;
- ❑ Billing ONLY 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 Health: APD, Cheshire Medical Center, DHHC, DHMC, DHC, Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney, NLH or VRH, 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 Health.

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 Health. Submitting a new form will revoke an existing form.

_____

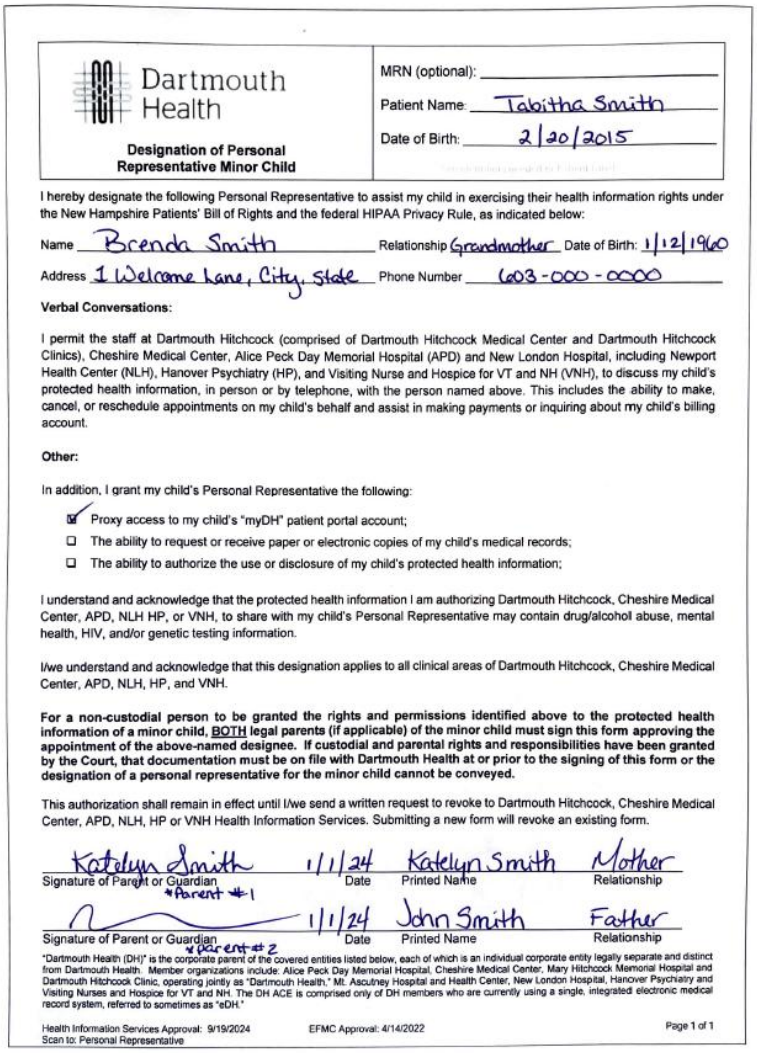
Signature of Parent or Guardian Date Printed Name Relationship

_____

Signature of Parent or Guardian Date Printed Name Relationship

"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, Dartmouth Health Home Care, 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 Valley Regional Hospital 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 DOCUMENT:



Dartmouth Health

Designation of Personal Representative Minor Child

MRN (optional): _____

Patient Name: Tabitha Smith

Date of Birth: 2/20/2015

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 Brenda Smith Relationship Grandmother Date of Birth: 1/12/1960

Address 1 Welcome Lane, City, State Phone Number 603-000-0000

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, BOTH 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.

Katelyn Smith 1/1/24 Katelyn Smith Mother
Signature of Parent or Guardian *Parent #1 Date Printed Name Relationship

1/1/24 John Smith Father
Signature of Parent or Guardian *parent #2 Date Printed Name Relationship

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Health Information Services Approval: 9/19/2024 EFMC Approval: 4/14/2022 Page 1 of 1
Scan to: Personal Representative

Returning your Designation of Personal Representative Form for myDH Portal Access – Send form to: myDH@hitchcock.org

- ❑ **Alice Peck Day Memorial Hospital**, HIS Dept., 10 Alice Peck Day Drive, Lebanon, NH 03766, Ph: 603-650-7110, Fax: 603-640-1970
- ❑ **Cheshire Medical Center**, HIM Dept., 590 Court Street, Keene, NH 03431, Ph: 603-354-5477, Fax: 603-676-4253 email: *cmcroi@cheshire-med.com*
- ❑ **Dartmouth Health Home Care,** *Health Information Services, 1 Medical Center Drive, Lebanon, NH 03756, Ph: 603-650-7110, Fax: 603-727-7869*
- ❑ **Dartmouth Hitchcock Medical Center**, HIS Dept., 1 Medical Center Drive, Lebanon NH 03756, Ph: 603-650-7110, Fax: 603-727-7406 email: *HIS@hitchcock.org*
- ❑ **Hampstead Hospital**, HIM Dept., 218 East Road, Hampstead, NH 03841, Ph: 603-329-5311, Fax: 603-329-9460
- ❑ **Hanover Psychiatry**, 23 S. Main Street, Suite 2B, Hanover, NH 03755, Ph: 603-277-9110, Fax: 603-277-9154
- ❑ **DH Manchester, Nashua & Concord**, HIS Dept., 100 Hitchcock Way, Manchester, NH 03104, Ph: 603-695-2820, Fax: 603-727-7828 email: *DH-ROI@hitchcock.org*
- ❑ **Mt. Ascutney Hospital and Health Center**, HIM Dept., 289 County Road, Windsor, VT 05089, Ph: 802-674-6711, Fax: 603-727-7904 email: *HIM@mahhc.org*
- ❑ **New London Hospital**, HIS Dept., 273 County Road, New London, NH 03257, Ph: 603-526-5247, Fax: 603-526-5051 email: *NLHMedicalRecords@NewLondonHospital.org*
- ❑ **Newport Health Center**, ROI Dept., 11 John Stark Highway, Newport, NH 03773, Ph: 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 email: healthinfo@vrh.org