Dartmouth Health

**Designation of Personal Representative**

MRN (optional):_____

Patient Name: _____

Date of Birth: _____

Two identifiers needed or Patient Label

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 _____ 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 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:

- ❑ Full Proxy access to my "myDH" patient portal account;
- ❑ Billing ONLY 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, DHHC, DHMC, DHC, Hampstead Hospital, Hanover Psychiatry, Mt. Ascutney, NLH or VRH, 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.

_____

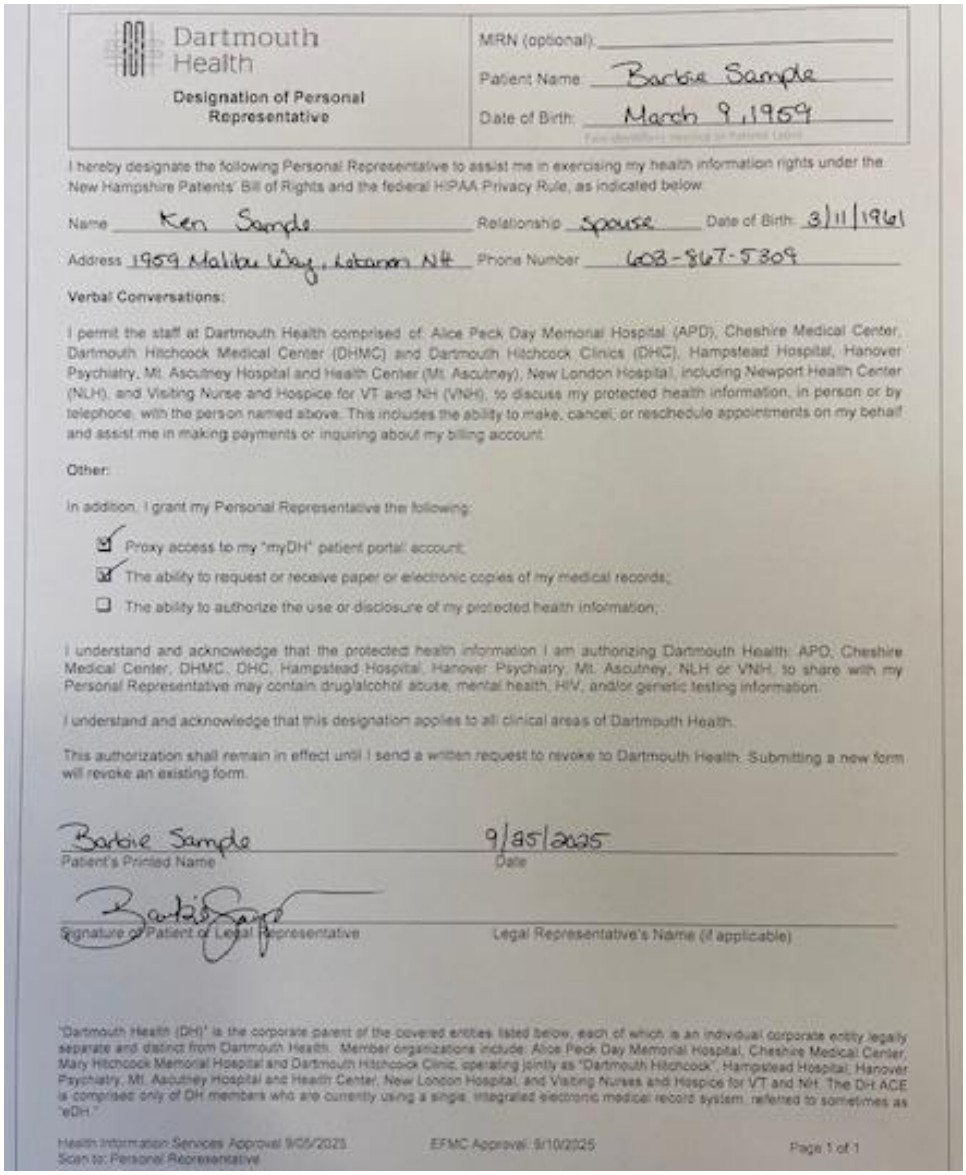
Patient's Printed Name Date

_____

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, 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**

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: 603-867-5309

**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 — Patient's Printed Name

9/25/2025 — Date

Barbie Sample — Signature of Patient or Legal Representative

Legal Representative's Name (if applicable)

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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