north country healthcare

Designation of Personal Representative

Patient Name (print):_____ Date of Birth:_____

I hereby designate the following Personal Representative to assist me in exercising my health information right under the New Hampshire Patients' Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR 164.510 (b)), as indicated below:

Name: _____ Date of Birth: _____
Address:_____ Phone: _____
Relationship: _____

Name: _____ Date of Birth: _____
Address:_____ Phone: _____
Relationship: _____

Name: _____ Date of Birth: _____
Address:_____ Phone: _____
Relationship: _____

Initial below:

_____ I request that my personal representative be allowed to assist me in exercising the following rights related to my protected health information. I understand and acknowledge that my protected health information may contain drug/alcohol abuse, mental health, HIV and/or genetic testing information.

_____ I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and I provide my consent for disclosure.

Please check all applicable items:

☐ The right to communicate verbally regarding my appointments/medical care.
☐ The right to have verbal communications with my health care team regarding services rendered; test results; and any information relating to my health care.
☐ Billing information.
☐ Copies of my medical records.
☐ Other (please specify) _____

Select One:

☐ No Expiration ☐ Expires On:_____(Date)

I understand that if I no longer wish for this Personal Representative Designation to be in effect, I must revoke the designation in writing. I also understand that it is my responsibility to notify my designee that I have revoked their access to my protected health information.

Patient Signature: _____ Date: _____ Time: _____