MID-STATE HEALTH CENTER
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
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midstatehealth.org

Designation of Personal Representative - *Optional*

Patient Name: ______________________________ **DOB:** ____________________
Address: ______________________________ **City:** ____________________
State: ____________________ **Zip:** __________ **Phone Number:** ________________

I hereby designate the following Personal Representative to **assist me in exercising my health information rights,** related to care received at Mid-State Health Center, under the New Hampshire Patient's Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR 164.502(g).

You may nominate a Personal Representative to assist in obtaining and receiving services at MSHC. This Personal Representative does not have equal rights and responsibilities as a Durable Power of Attorney. The Representative can only assist in exercising your **health information rights.**

My designated Personal Representative is:
Name: ____________________ **Phone:** ______________ **Relation to patient:** ______________
Address: ______________________ **City/ State:** ______________ **Zip Code:** ________

I request that my Personal Representative be allowed to assist me in exercising the following rights related to my **protected health information (PHI)**: (check all that apply)

_____ The right to execute, on my behalf, any medical consents, or other documents that may be required in order to exercise my health information rights; (including sliding fee application)
_____ The right to request and obtain a copy of my **medical records** and other PHI
_____ The right to request an amendment of any of my protected health information and/or request an accounting of disclosures of my protected health information
_____ The right to **communicate verbally** regarding my appointments; (cancel, schedule or reschedule)
_____ The right to have verbal discuss my health concerns with my provider and care team
_____ Other (please specify:)____

Restriction(s): ____

☐ No expiration Date
☐ Expires on (MM/DD/YYYY): ____________________

I understand if I wish to revoke personal representative designation, I must deliver notice of written revocation to: Mid-State Health Center – Health Information Management. I understand that it is my responsibility to notify my designee that I have revoked their personal representative designation. Submitting additional Personal Representative Forms will **NOT** revoke existing forms.

______________________________ ____________________
Patient's Name **(Print)** Date:

______________________________ ______________________________
Patient **(Signature)** / Legal Guardian (Signature) Printed Legal Guardian's Name (If Applicable)