

LAMPREY HEALTH CARE

Authorization for Designation of Personal Representative

Patient Name: _____

DOB: _____

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patient Bill of Rights (NH RSA 151:21,X) and the Federal Privacy Rule (45 CFR 164.502 (g)), as indicated below.

This designation does not expire but may be cancelled by contacting the LHC Medical Record Department.

My designated Personal Representative is:

Name: _____

Address: _____

Phone #: _____

Relationship to patient: _____

I request that my Personal Representative be allowed to assist me in exercising the following rights related to my protected health information:

Draw a line through those items that do not apply.

My Personal Representative may obtain a copy of my medical records

My Personal Representative may discuss my care with my provider or other health care staff as applicable

My Personal Representative may schedule appointments

My Personal Representative may discuss and receive billing information

Other _____

In addition, I authorize Lamprey Health Care to release/discuss with my Personal Representative information relating to the following:

Draw a line through those items that do not apply.

- Acquired Immunodeficiency Virus HIV Infection
- Psychiatric care
- Genetic Testing
- Treatment for alcohol and/or substance abuse

Signature of Patient or Legal Guardian/Parent

Date

Print name of Patient or Legal Guardian/Parent

Relationship to Patient