Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Mt. Ascutney Physician Practice

REQUEST TO DESIGNATE A PERSONAL REPRESENTATIVE

Patient Name: _____
Date of Birth: _____
MRN: _____

I hereby request that the following individual be treated as my personal representative with regard to my protected health information:

_____
Name of Personal Representative Relationship and Date of Birth

_____
Address Phone

I understand that by naming this individual as a personal representative I am granting him/her the same rights of access to my protected health information as I have myself. Mt. Ascutney Hospital and Health Center, the Mt. Ascutney Physician's Practices and Ottauquechee Health Center will be allowed to provide information to this person without my specific consent or authorization. This includes verbal communication and access to my written records, including being allowed to inspect the record and request copies on my behalf. 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 Mt. Ascutney Hospital and Health Center and its associated physician practices are not liable for any inappropriate disclosure or breach of privacy that may result from disclosures made to the above named individual acting in the capacity of personal representative.

I understand that if I no longer wish for this Personal Representative designation to be in effect, I must revoke the designation in writing to Mt. Ascutney Hospital and Health Center. I also understand that it is my responsibility to notify my designee that I have revoked his or her access to my protected health information

Expiration Date: _____ (indicate none if applicable)
Expiration Event: _____ (indicate none if applicable)

_____ _____
Signature of Patient or Legal Guardian Date

_____
Legal Guardian Name if Applicable

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