# Seacoast Dermatology, PLLC

Mailing Address: 330 Borthwick Ave Suite 303 Portsmouth, NH 03801
Phone: (603)431-5205 Fax: (603) 436-4257

## Please complete IF you wish to designate a *Personal Representative* to help you manage your healthcare.

**My Designated Representative is:** **Relationship:** ______________________________

**Name:** ________________________________________ **Phone:** ________________________________

**Address:** ____________________________________________________________________________

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

**Please check all that apply.**

____ **The right to have verbal communication with my healthcare team.**

____ **The right to access and obtain a copy of my medical records or related information.**

____ **The right to authorize use or disclosure of my protected health information.**

____ **The right to request an amendment of any protected health information.**

**Other:** ______________________________________________________________________________

**Expiration: None** ***OR*** **Expires on** __________________________**(date)**

I understand that if I no longer wish for this Personal Representative to be in effect, I must revoke the designation in writing to Seacoast Dermatology, PLLC. I also understand that is it my responsibility to inform my designee that I have revoked or changed his or her access to my protected health information.

_____________________________________________ _____________________________

**Patient's Name** **Date**

_____________________________________________ _____________________________

**Signature of Patient or Legal Guardian** **Name of Guardian (if applicable)**