

Power of Attorney (Fullmakt)

I
(patient's name) hereby give power of

attorney to
(name of agent)

(address of agent)

(agent's postal code and city)

(agent's phone number)

(agent's e-mail address)

to represent me before the Patients' Advisory Committee administration (Patientnämndens förvaltning), and to have access to all documents pertaining to my case.

City

Date

Patient's signature

Patient's ID number

Name in print

To offer the best possible service and help improve quality and patient safety in healthcare and dentistry, we need to process the personal data that you submit in this form. Anonymous data from your complaint is used for statistics that we compile for care providers, local authorities and other parties to improve the quality and safety of healthcare. Please contact us for further information.