VÄSTRA GÖTALANDSREGIONEN
PATIENTNÄMNDERNAS KANSLI

010-441 20 00
www.vgregion.se/patientnamnden

Send this form to:

Patientnämndernas kansli
Regionens hus
405 44 Göteborg

POWER OF ATTORNEY

Use this form when you wish to appoint another person as your liaison with the Patient Advisory Board.

By signing this form, you give another person permission to represent you. This is known as conferring "power of attorney" upon the person. Once you have given them this authority, we will contact this person instead of you. You can revoke this person's power of attorney at any time. Contact us if you no longer wish the person selected to act as your liaison with the Patient Advisory Board.

By signing this form, you give the Patient Advisory Board the right to share confidential information concering you with the healthcare system and with the person to whom you give power of attorney. "Confidential information concerning you" refers to everything regarding the matter you submitted to us, such as information about your health status and other personal circumstances, for example.

1. The person conferring power of attorney

First name & surname		Personal ID No. (personnummer)
Postal address	Postcode & city/town	

2. The person on whom you confer power of attorney

First name & surname		Personal ID No. (personnummer)
Postal address	Postcode & city/town	
E-mail adress	Home phone No. (incl. area code)	Work/moble phone No.

3. To what do you wish the power of attorney to apply?

☐ The matter submitted to the Patient Advisory Board concerning me.

4. How long do you wish the power of attorney to apply?

☐ The power of attorney is valid from the date specified below until the matter is concluded.

5. Signature of the person conferring power of attorney

I give my agent the right to represent me in interactions with the Patient Committee.		Home phone No. (incl. area code)
Date	Signature	Work/mobile phone No.

The Patient Advisory Board processes personal data digitally. Learn more about our personal data processing at www.vgregion.se/patientnamnden

Please print out, sign and send in the original copy of this form.