SAHLGRENSKA UNIVERSITETSSJUKHUSET VGR

Medical records request
Power of Attorney

Patient information

First name, Surname	Date of Birth (yyyy-mm-dd) or Swedish identity number

Requested documents

Sahlgrenska University Hospital: Sahlgrenska Hospital ☐ Mölndals Hospital ☐ Östra Hospital ☐	Time Period (date or year range, e.g. 2022–2025)
Clinic (e.g. Emergency Department)	Medical records: Patient records (Doctors notes) ☐ Other documents ☐
Specify any other records you are requesting (e.g., notes from another staff category such as a physiotherapist or psychologist, or specific documents such as a radiology report or biopsy result)	
Purpose and additional information (e.g. insurance claim and other details that may help us process your request)	

In accordance with Avgiftsförordningen (1992:191), the first 1–9 copies are free of charge. The fee for 10 pages of medical record copies is 50 Swedish crowns. For each additional page, the fee is 2 Swedish crowns, with a maximum fee of 300 Swedish crowns.

Postal Adress
Sahlgrenska Universitetssjukhuset
Arkiv och informationsstruktur
Journalbeställning
413 45 Göteborg

Arkiv och informationsstruktur
Tel 031-343 91 00 (09:00 - 11:00)
Fax 010-168 76 74

Sahlgrenska Universitetssjukhuset
413 45 Göteborg
031-342 10 00 - sahlgrenska.se

Relation to the patient

Specify your relationship to the patient. If you are the legal guardian of a minor, no power of attorney is required. If you have another relationship to the patient, please indicate the nature of your relationship, e.g. daughter or grandchild. For other relationships to an adult patient, a power of attorney must be obtained from the patient. If the patient is deceased, no power of attorney is required.

☐ Legal guardian *(no power of attorney required)*

☐ Other relation: _____

☐ Patient deceased *(no power of attorney required)*

Power of Attorney

I hereby grant the recipient a power of attorney to request and receive copies of my patient records on my behalf. This power of attorney covers only the documents explicitly specified on page 1 of this request. It does not extend beyond the mentioned documents and expires once these documents have been released.

Signature (patient)	Printed name
Date (yyyy-mm-dd)	Date of Birth (yyyy-mm-dd) or Swedish identity number

Recipient

First name, Surnamn	Date of Birth (yyyy-mm-dd) or Swedish identity number
Postal Address	
Telephone number	
Date (yyyy-mm-dd)	Signature (recipient)

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