Region Stockholm
PATIENTNÄMNDENS FÖRVALTNING

Reference number
(filled in by the Patients' Advisory Committee)

Power of Attorney (Fullmakt)

I _____ hereby give power of
(patient's name)

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.

Send the form to:
Patientnämndens förvaltning
Box 30198
104 25 Stockholm

Phone 08-123 467 00
E-mail registrator.pan@regionstockholm.se
www.regionstockholm.se/patientnamnden

FEBRUARY 2024