**POWER OF ATTORNEY TO ACT ON MY BEHALF AT TERVEYSTALO**

*With this power of attorney, a person over the age of 18 with contractual capacity\* can give* *another person over the age of 18 with contractual capacity the right to act on their behalf at Terveystalo.*

*\* Having contractual capacity means that the person is capable of entering a legally binding contract, such as giving a power of attorney. Contractual capacity can be restricted, for example, in connection with ordering a trustee.*

**Principal** (*to be filled in by the principal*)

|  |
| --- |
| First and last name: |
| Personal identity code: |
| Address: |
| Telephone number:  |

**Agent** *(to be filled in by the agent)*

|  |
| --- |
| First and last name: |
| Personal identity code: |
| Address: |
| Telephone number:  |

**Scope of the PoA** (*to be filled in by the principal*)

With this Power of Attorney, I grant the following powers to the above agent at Suomen Terveystalo Oy:

[ ]  **to receive information about my scheduled appointments and to change them**

with the following restrictions *(write here if you want this PoA to only apply to a certain condition, accident, time period, day of visit, physician or Terveystalo clinic):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **to enquire about my laboratory results**

with the following restrictions *(write here if you want this PoA to only apply to a certain test or examination, time period, day of visit or Terveystalo clinic):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **to receive information about my prescriptions and to renew or cancel my prescriptions**

with the following restrictions *(write here if you want this PoA to only apply to a certain prescription, physician, time period or day of visit):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **to request and pick up my patient records**

[ ]  **to handle matters related to payments and invoices**

I understand that, in order to act on my behalf, the Agent has the right to access information that would otherwise be confidential (e.g. information about my scheduled appointments and my health status).

**Validity** (*to be filled in by the principal*)

This Power of Attorney shall be valid for a fixed period of time, until \_\_\_\_ /\_\_\_\_.20\_\_\_\_ (but not exceeding 2 years).

I am aware that I may revoke this Power of Attorney and end this authorization at any time by written notice to a Terveystalo clinic. A form provided by Terveystalo can be used to this end.

[ ]  At the same time, I revoke all previous Powers of Attorney to act on my behalf I have granted *(to be filled in by the principal*)

**Signature of the Principal Signature of the Agent**

Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and printed name Signature and printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The Principal must personally submit this Power of Attorney to a Terveystalo clinic. In exceptional cases, also the Agent may submit the Power of Attorney, but in that case it must be signed by two witnesses over the age of 18 with contractual capacity.*

**Witnesses** *(only to be filled in if the Principal is unable to come to the clinic to prove their identity)*

We witness that this Power of Attorney was signed by the Principal of their free will and in our presence, with an understanding of the importance of this matter.

Signature and printed name /date Signature and printed name/date

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *The identity of the person submitting the PoA will be verified using an official identity document (see below). The identity of the Agent will be verified in connection with the use of the PoA.*

**Receipt of the Power of Attorney** *(to be filled in by Terveystalo)*

The Power of Attorney was submitted by

[ ]  the Principal (the person granting the PoA)

[ ]  Agent

The identity of the person submitting the PoA has been verified using an official identity document:

[ ]  **Passport** (valid)

[ ]  **Official photo identity document** (issued by the Police of Finland)

[ ]  Identity card issued elsewhere in the EEA (European Economic Area, San Marino and Switzerland)

[ ]  **Driver’s license** (issued by Finnish authorities)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the person who received the PoA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic of the person who received the PoA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_