Power of attorney for retreiving healthcare information at HSS

A complete and filled out power of attorney must be presented when documents are retrieved

I signed _____

Social security number: _____

I hereby grant the following party a power of attorney to collect data for me, delivered to the Suðurnes Hospital & Health Center.

_____ kt. _____

_____ Date:_____
Signature of the agent

Witnesses:

Name: _____ kt. _____

Name: _____ kt. _____