

## Power of attorney

I, \_\_\_\_\_  
name of parent/ legal guardian of a minor

Passport \_\_\_\_\_ (series)\_ \_\_\_\_\_ (number),

trust \_\_\_\_\_ (issuing authority, date of issue)

trust \_\_\_\_\_ (issuing authority, date of issue)

(name, grandparents, babysitters, uncles, aunts, etc .)

Passport \_\_\_\_\_ (series) \_\_\_\_\_ \_ number

(issuing authority, date of issue)

to represent my interests in the relations with LLC

in case of treatment/examination of my child

(name of child)

Birth certificate: \_\_\_\_\_ (series)\_ \_\_\_\_\_ number

(issuing authority, date of issue)

in particular:

- sign on my behalf the contract and all appendices to the contract for provision of paid medical services to my child;
- make all decisions regarding the health of my child and sign voluntary informed consent to medical interventions, refusals of medical interventions, examination and treatment plans;
- pay for the treatment of the child;
- receive information about my child's health at a doctor's appointment, orally, in the form of copies and extracts from medical documentation.
- receive certificates, financial documents, results of examination and treatment.

The power of attorney was issued for a period of 3 years without the right of transfer.

Full name Signature  
(parent / legal representative of a minor)

Full name Signature (trustee)

Date the power of attorney was issued