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AVICENNA
swiss premium care

POWER OF ATTORNEY

Authoriser (Patient):
Surname, first name:
Date of birth:
Place of birth:
Nationality:
Address:

Authorised Representative

Company: Avicenna GmbH
Address: Bahnhofstrasse 10, 8001 Zürich, Switzerland

I hereby authorise the representative to act on my behalf regarding the registration for treatment or consultation at the Hospital, particularly for the processes marked below. The representative may provide required consents and explanations. Doctors and medical facilities are released from their duty of confidentiality toward my authorised representative for the purposes listed below.

The authorised representative is specifically permitted to act in my name and on my behalf concerning the following (multiple entries possible):

- ☐ receive and respond to all correspondence from the Hospital;
- ☐ receive health information from the Hospital and send health information to the Hospital;
- ☐ make advance payments;
- ☐ receive and pay Hospital invoices;
- ☐ request additional services from the Hospital.

(Please tick as required and/or state further services.)

This power of attorney is expressly limited to the administrative processes above and does not include representation in the case of incapacity as defined under the Swiss Civil Code (Art. 370).

This power of attorney shall remain valid even in the event of any unforeseen circumstance that affects the authoriser's ability to personally follow up on the procedures. It may be revoked, limited, or extended in writing at any time. The authorised representative is not permitted to issue a sub-authorisation.

Swiss law applies exclusively. The place of jurisdiction is Zurich.

Place, date:
Patient signature:
→ Please attach a copy of the authoriser's passport.