POWER OF ATTORNEY

We the undersigned:

1. Name: _____ ID/passport_____
2. Name: _____ ID/passport_____

appoint and authorize:

1. Name: _____ ID/passport_____
2. Name: _____ ID/passport_____

All together and each of them separately, to come as a living and to perform and act for me / in my name / in and in my place / in

Request and receive medical information about me regarding the medical affairs of your institution.

I declare that in accordance with the above, I will not have any future claims/complained against Rambam Hospital for the provision of medical information.

Name:……

Date .....

Signature ..... ID/Passport.....