

POWER OF ATTORNEY

I, the undersigned
Place and date of birth:.....
Mother's name:
Identity card:.....
Address:.....
as Granter, based on Section 24, paragraphs (7) and (8) of Act CLIV of 1997 on healthcare

hereby grant an authorisation

to the below natural person

Name:
Place and date of birth:.....
Mother's name:.....
Identity card:.....
Address:.....

to take over, in my name and on my behalf **my healthcare documentation or** **[to be specified exactly]** from the healthcare provider Liv Duna Medical Center Kft. (registered office: H-1095, Budapest, Lechner Ödön fasor 5, company registration number: Cg.01-09-191967, tax number: 24963145-2-41, operating licence No: 47166-6/2021/EÜIG). This power of attorney is for fulfilling the above task and it is valid until withdrawal.

Budapest, 2024 /.....

Time : /

.....
Granter

I, the undersigned hereby accept the above authorisation.

.....
Attorney-in-fact

We, acting as Witnesses:

.....
Signature

.....
Signature

.....
Name

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Name

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Address

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Address

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Identity card No.

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Identity card No.