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| **ДОВЕРЕННОСТЬ** | **LETTER OF AUTHORIZATION** |
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| г. Москва | «\_\_\_»\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_год |

Я,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| city of Moscow | \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_ |

I, the undersigned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (Ф.И.О. одного из родителей (или иного законного представителя) ребёнка) | (First name, patronymic, last name of one of the parents (or other legal representative) of the child) |
| паспорт серия\_\_\_\_\_\_\_\_\_\_\_\_\_№\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_выдан\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_«\_\_\_»\_\_\_\_\_\_\_\_\_201\_\_\_\_г. | passport series \_\_\_\_\_\_\_\_\_\_\_\_\_ No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, issuing authority \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of issue \_\_\_ \_\_\_\_\_\_\_\_\_ 201\_\_\_\_ |
| доверяю\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (кому - Ф.И.О. доверенного лица) | (First name, patronymic, last name of the Letter of Authorization holder) |
| паспорт серия\_\_\_\_\_\_\_\_\_\_\_\_\_№\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_выдан\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_«\_\_\_»\_\_\_\_\_\_\_\_\_201\_\_\_\_г. | passport series \_\_\_\_\_\_\_\_\_\_\_\_\_ No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, issuing authority \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of issue \_\_\_ \_\_\_\_\_\_\_\_\_ 201\_\_\_\_ |
| сопровождать моего ребенка/моих детей\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_«\_\_\_»\_\_\_\_\_\_\_\_\_201\_\_\_\_г. | to accompany my child/my children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_ 201\_\_\_\_ |
| (Ф.И.О. ребёнка, дата рождения) | (First name, patronymic, last name of the child, date of birth) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_«\_\_\_»\_\_\_\_\_\_\_\_\_201\_\_\_\_г. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_ 201\_\_\_\_ |
| (Ф.И.О. ребёнка, дата рождения) | (First name, patronymic, last name of the child, date of birth) |
| в стоматологическую клинику «Дентал Фэнтези» или в детскую клинику «Фэнтези» (с правом подписывать за меня документы, связанные с лечением моего ребенка, в том числе: анкету здоровья, договор оказания платных медицинских услуг, план лечения, информированное добровольное согласие на виды медицинских вмешательств, включенных в Перечень определенных видов медицинских вмешательств, на которые граждане дают информированное добровольное согласие при выборе врача и медицинской организации для получения первичной медико-санитарной помощи, утвержденный приказом Министерства здравоохранения и социального развития Российской Федерации от 23 апреля 2012 г. № 390н, а также подписывать отказы от указанных медицинских вмешательств, оплачивать данные услуги, получать полную и достоверную информацию о здоровье моего ребенка, как на приеме врачей, так и в виде копий медицинской документации, оригиналов медицинской документации и выписок из нее, а также выполнять все иные действия, связанные с выполнением данного поручения). | to the “Dental Fantasy” dental clinic or to the children's clinic “Fantasy” (with the right to sign documents related to the treatment of my child, including: a health questionnaire, a contract for the provision of paid medical services, a treatment plan, a voluntary informed consent form to the types of medical interventions included in the List of certain types of medical interventions requiring the provision by patient of the voluntary informed consent when choosing a doctor and medical institution to obtain primary health care, as approved by Order No. 390n of the Ministry of Health and Social Development of the Russian Federation of April 23, 2012, as well as sign refusals to undergo these medical interventions, pay for these services, receive complete and reliable information about the health of my child, both at the doctor’s office and in the form of copies of medical records, originals of medical records and extracts therefrom, as well as perform any other activities related to the implementation of this authorization). |
| Доверенность выдана на срок\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The Letter of Authorization is issued for a period of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Подпись\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_удостоверяю. | I hereby certify the signature of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| (Подпись доверенного лица) | (Signature of the Letter of Authorization holder) |
| Подпись\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_удостоверяю. | I hereby certify the signature of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| (Подпись родителя ребёнка) | (Signature of the child’s parent) |
| Документы проверил\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | The documents are verified by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (Ф.И.О. и подпись сотрудника клиники)  | (First name, patronymic, last name and signature of the clinic employee)  |