[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Doctor's Name]
[Medical Facility Name]
[Facility Address]
[City, State, Zip Code]
Subject: Authorization for Medical Treatment
Dear [Doctor's Name],
I, [Your Name], hereby authorize [Name of Authorized Person], my [relationship, e.g., parent, spouse, guardian], to make medical decisions on my behalf and to consent to any medical treatment that may be necessary for my well-being.
This authorization includes, but is not limited to, examinations, tests, surgeries, and any other treatments as deemed appropriate by my healthcare provider.
This authorization is valid until [end date or "until revoked in writing"].
If you have any questions or require further verification, please do not hesitate to contact me at the number listed above.
Thank you for your attention to this matter.
Sincerely,
[Your Signature]
[Your Printed Name]
[Your Date of Birth]
[Optional: Social Security Number]