[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Medical Facility Name]
[Facility Address]
[City, State, ZIP Code]

Subject: Letter of Authorization for Medical Treatment

Dear [Recipient Name],

I, [Your Full Name], hereby authorize [Name of Authorized Person], my [relationship to the patient, e.g., "parent", "guardian", "spouse"], to act on my behalf regarding all medical treatment decisions for [Patient Name], who is my [relationship to the patient, e.g., "child", "spouse"].

This authorization includes, but is not limited to:

- Access to medical records
- Consent for medical procedures
- Communication with healthcare providers

This authorization is effective immediately and will remain in effect until [end date or "further notice"].

Please provide [Authorized Person's Name] with any necessary information required to facilitate the medical treatment process.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]