[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Healthcare Provider's Name]
[Facility Name]
[Facility Address]
[City, State, ZIP Code]
Subject: Consent for Medical Procedure
Dear [Healthcare Provider's Name],
I, [Your Full Name], hereby give my consent for the medical procedure described below.
Procedure: [Name of the procedure]
Date of Procedure: [Scheduled date]
Location: [Facility/Clinic Name and Address]
I understand the nature of the procedure, its benefits, risks, and potential complications. I have had the opportunity to ask questions regarding the procedure, and all my questions have been answered to my satisfaction.
I acknowledge that I have been informed about any alternatives to the proposed treatment and the risks of not undergoing the treatment.
By signing this document, I confirm that I am the patient, or I am duly authorized to provide consent on behalf of the patient.
Patient Signature: _____
Date: _____
If applicable (for a guardian or representative):
Name: _____
Relationship to Patient: _____
Signature: _____
Date: _____
Thank you for your attention to this matter.
Sincerely,
[Your Name]