[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Healthcare Provider's Name]
[Clinic/Hospital Name]
[Address]
[City, State, ZIP Code]

Dear [Healthcare Provider's Name],

Subject: Consent for IUD Removal

I, [Your Full Name], born on [Your Date of Birth], hereby give my consent for the removal of my intrauterine device (IUD) as discussed during my recent appointment on [Date of Appointment].

I understand the procedure involved in the removal of the IUD and have had the opportunity to ask questions regarding the process, possible risks, and post-removal care.

I acknowledge that I am receiving this procedure voluntarily and understand that I can withdraw my consent at any time before the procedure is performed.

Please proceed with the IUD removal at your earliest convenience.

Thank you.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]