[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Job Title]
[Company/Organization Name]
[Company Address]
[City, State, Zip Code]

Dear [Recipient's Name],

Subject: IV Therapy Consent

I, [Your Name], hereby give my consent to undergo intravenous (IV) therapy as recommended by my healthcare provider, [Provider's Name]. I understand that IV therapy involves the administration of fluids, medications, and/or nutrients directly into my bloodstream through a vein.

I have been informed about the purpose of the therapy, potential benefits, risks, and alternative treatment options. I understand that while IV therapy can be beneficial, there are possible side effects and complications, including but not limited to infection, phlebitis, allergic reactions, and fluid overload.

I confirm that I have had the opportunity to ask questions and that my questions have been answered to my satisfaction. I agree to follow all post-treatment instructions provided to me.

By signing below, I acknowledge that I consent to the IV therapy as described above.

Patient Name: _____
Patient Signature: _____
Date: _____
Witness Name: _____
Witness Signature: _____
Date: _____

Sincerely,
[Your Signature]
[Your Printed Name]