[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],

I, [Patient's Full Name], hereby give my consent for the administration of intravenous (IV) therapy as recommended by my healthcare provider. I understand that this therapy is intended to [briefly explain purpose, e.g., deliver medications, fluids, nutrients].

I have been informed about the possible risks and benefits associated with IV therapy, including [briefly outline risks and benefits]. I have had an opportunity to ask questions and understand the procedure and the expected outcomes.

I acknowledge that I have the right to withdraw this consent at any time prior to the initiation of the therapy.

Patient's Signature: _____

Date: _____

[If applicable, include guardian's signature if patient is a minor]

Guardian's Signature: _____

Date: _____

Thank you for your attention to this matter.

Sincerely,

[Your Name]