[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]
Subject: Consent for IUD Removal
Dear [Healthcare Provider's Name],
I, [Your Full Name], born on [Your Date of Birth], hereby give my consent for the removal of my intrauterine device (IUD) by [Healthcare Provider's Name] at [Clinic/Hospital Name].
I understand the procedure involved in the removal of the IUD and the potential risks and benefits associated with it. I have had the opportunity to ask questions and have received satisfactory answers regarding the procedure.
I consent to the removal of my IUD on [preferred date] and acknowledge that I can withdraw my consent at any time prior to the procedure.
Patient Signature: _____
Date: _____
Thank you.
Sincerely,
[Your Name]