[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Position/Title]
[Institution/Organization Name]
[Address]
[City, State, Zip Code]
Subject: Medical Consent Letter

Dear [Recipient's Name],

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby give my consent for [Patient's Full Name] to receive medical treatment from [Provider/Institution Name].

I understand that this medical treatment may include [brief description of the treatment/procedure]. I have been informed of the purpose, potential risks, and expected outcomes associated with the treatment.

This consent is valid from [Start Date] to [End Date].

If you have any questions or require further information, please feel free to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Relationship to Patient] (if applicable)