[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Healthcare Provider's Name]
[Healthcare Provider's Address]
[City, State, Zip Code]
Subject: Authorization for Xtandi Treatment
Dear [Healthcare Provider's Name],
I, [Patient's Name], born on [Patient's Date of Birth], hereby authorize you to provide me with Xtandi (enzalutamide) as part of my treatment plan.
I understand the indications, dosage, and potential side effects associated with Xtandi. I consent to the treatment and acknowledge that I may withdraw my consent at any time.
Please contact me should you require any additional information or documentation.
Thank you for your attention to this matter.
Sincerely,
[Patient's Signature]
[Patient's Printed Name]
[Patient's Medical Record Number (if applicable)]