[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title]
[Medical Facility Name]
[Facility Address]
[City, State, Zip Code]
Subject: Authorization Letter for Medical Purposes
Dear [Recipient's Name],
I, [Your Full Name], hereby authorize [Authorized Person's Name], [Relationship to You], to act on my behalf regarding all medical matters, including but not limited to obtaining medical records, discussing my treatment options, and making medical decisions as necessary.
This authorization is effective immediately and will remain in effect until [end date or specify condition].
Please provide [Authorized Person's Name] with the necessary information and assistance regarding my medical care.
Thank you for your attention to this matter.
Sincerely,
[Your Signature]
[Your Printed Name]
[Your Date of Birth]
[Your Patient ID Number, if applicable]