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| |  | | --- | | **Authority Letter**  for Medical Treatment |  |  | | --- | | To  [Receiver Name]  [Receiver Title]  [Addess]  [Email] | |  | | From  [Sender Name]  [Sender Title]  [Addess]  [Email] | | |  | | --- | |  | |  |   Dear [Your Name]  I, [Your Full Legal Name], hereby authorize the medical professionals at [Medical Facility's Name] to provide medical treatment and care to my [Family Member's Full Name] in my absence.  This authorization includes consenting to any necessary medical procedures, surgeries, and administration of medications. [Family Member's Full Name] is [Your Relationship to Family Member, e.g., spouse, child, parent], and I grant them full authority to make medical decisions on my behalf.  By notarizing this letter, I affirm that I have willingly granted this authorization and that [Family Member's Full Name] is aware of their responsibilities in my absence.  Sincerely,  [Your Full Legal Name]  [Notarization Statement] |