|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **ATHORITY LETTER**  Medical Treatment | |  | |  | | To  [Receiver Name]  [Receiver Title]  [Addess]  [Email] | |  | | From  [Sender Name]  [Sender Title]  [Addess]  [Email] | | |  | | --- | |  | |  | | **Subject**: Authorization for Medical Treatment on Behalf of [Patient's Name]  Dear [Recipient's Name],  I am writing to formally authorize [Agent's Name] as the responsible individual for making medical decisions and overseeing the medical treatment of [Patient's Name], in the event that I am unable to do so myself. I understand the importance of having a trusted person to act on my behalf in situations where timely medical decisions are required, and I have full confidence in [Agent's Name]'s ability to make informed choices for [Patient's Name]'s well-being.  This authorization is necessary to ensure that appropriate and timely medical care is provided to [Patient's Name] under any circumstances that may arise. I trust [Agent's Name] to make decisions in line with [Patient's Name]'s best interests and to consult with medical professionals to determine the most suitable course of action.  **I grant** [Agent's Name] **the authority to:**   1. Make medical decisions on behalf of [Patient's Name], including consenting to or refusing medical treatments, surgeries, and procedures. 2. Access [Patient's Name]'s medical records, discuss their medical condition with healthcare providers, and obtain information related to their treatment. 3. Coordinate and communicate with medical personnel, specialists, and other relevant parties involved in [Patient's Name]'s healthcare.   Please provide [Agent's Name]with the necessary access and information to fulfill their role effectively. This authorization is effective immediately and remains in effect until revoked by me in writing.  I kindly request that you keep a copy of this letter on file for your records and share this information with the medical staff responsible for [Patient's Name]'s care.  Thank you for your attention to this matter. I appreciate your assistance in ensuring that [Patient's Name]'s medical needs are met, even in my absence.  Sincerely,  [Your Signature]  [Your Printed Name]  [Your Date of Birth]  **Enclosure:** Copy of [Agent's Name]'s identification and contact information. | |