**Authorization Letter for Medical Treatment**

**[SENDER'S NAME]**

**To**

[Recipient's Name]

[Recipient's Address]

[City, State, ZIP]

**From**

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Email Address]

[Contact no]

[Date]

Dear Dr. Johnson,

I, John Smith, residing at 789 Maple Lane, Anytown, USA, Date of Birth: January 15, 19XX, hereby authorize and designate Sarah Adams, residing at 321 Elm Street, Anytown, USA, Relationship: Spouse, Contact Number: (555) 123-4567, to act on my behalf as my authorized representative for making medical decisions and providing consent for medical treatment and procedures during the period of August 15, 20XX, to September 30, 20XX, or until revoked in writing.

 I understand that due to my recent surgery, I may be unable to provide consent for medical treatments or procedures. Therefore, I grant full authority to my authorized representative to:

 1. Make medical decisions and provide consent for any necessary diagnostic tests, surgeries, procedures, treatments, and medications recommended by healthcare professionals.

2. Access my medical records, discuss my medical condition with healthcare providers, and receive information related to my health status and treatment.

3. Execute any documents or agreements related to my medical treatment, as required by healthcare providers or medical facilities.

 This authorization also extends to any emergency medical situations that may arise during the specified period. I trust that my authorized representative will act in my best interests and consult with healthcare providers to make informed decisions regarding my health and well-being.

 I understand that I have the right to revoke this authorization at any time in writing, and I will promptly notify Sunshine Hospital of such revocation.

 I hereby acknowledge that I have read and understood the contents of this Authorization Letter and willingly grant the authority as specified herein.

 Sincerely,

John Smith

August 1, 20XX

 Witness: Susan Miller