**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 [Recipient's Name],

I, [Patient's Full Name], residing at [Patient's Address], Date of Birth: [Patient's DOB], hereby authorize and designate [Authorized Representative's Full Name], residing at [Authorized Representative's Full Address], Relationship: [Authorized Representative's Relationship], Contact Number:[Authorized Representative's Phone Number], 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 [Start Date] to [End Date] or until revoked in writing.

I understand that due to my [medical condition/incapacity], 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 the relevant medical facility or healthcare provider 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,

[Patient's Full Name]