Authorization Letter

(Medical Treatment Authorization Letter**)**

[Your Name]
[Your Address]
[City, State, ZIP Code]

[Date]

[Medical Facility Name]
[Medical Facility Address]

[City, State, ZIP Code]

Dear [Medical Facility Manager],

I, [Your Name], hereby authorize [Authorized Person's Name] to make medical decisions and consent to medical treatments on my behalf at [Medical Facility Name]. This authorization extends to all medical procedures, examinations, and treatments deemed necessary by the attending physicians.

This authorization is valid from [Start Date] to [End Date]. [Authorized Person's Name] is authorized to provide consent for medical procedures and sign all relevant documents during this period.

Your cooperation in facilitating [Authorized Person's Name]'s involvement in my medical care is greatly appreciated.

Sincerely,
[Your Signature]
[Your Name]