

Altered Medication Directive

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], of [Your Address], hereby declare that I have requested an alteration to my prescribed medication regimen.

This directive serves to inform all healthcare providers that my medication preferences have changed. The details are as follows:

Medication Details:

- Current Medication: [Insert Medication Name and Dosage]
- Requested Change: [Insert New Medication and Dosage]

Reason for Change: [Insert Reason for Alteration]

Please note that this directive is effective immediately and should be considered in all medical decisions regarding my treatment.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]