Surgical Procedure Authorization

Date: [Insert Date]

To: [Surgeon's Name]

[Clinic/Hospital Name]

[Address]

[City, State, Zip Code]

Dear [Surgeon's Name],

I, [Patient's Full Name], hereby authorize and give my consent for the surgical procedure known as [Procedure Name] to be performed on me. I have discussed the nature of the procedure, the potential risks and benefits, and any alternatives with my healthcare provider.

Details of the Procedure:

- **Procedure Name:** [Procedure Name]
- **Date of Procedure:** [Proposed Date]
- **Location:** [Clinic/Hospital Name]

I understand that I have the right to ask questions and that I can withdraw my consent at any time before the procedure is performed.

By signing below, I confirm that I have read and understood this authorization and that all my questions have been answered to my satisfaction.

Patient Signature: _____ Date: _____

Patient Printed Name: [Patient's Full Name]

Witness Signature: _____ Date: _____

Witness Printed Name: [Witness's Full Name]

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Contact Information]