Healthcare Treatment Authorization for Elective Surgery

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID]

Date of Birth: [DOB]

Procedure: [Name of the Elective Surgery]

Date of Surgery: [Scheduled Date]

Authorization Details

To Whom It May Concern,

I, [Patient's Full Name], hereby authorize [Healthcare Provider's Name] to provide medical treatment and perform the elective surgery as outlined above. I understand the risks associated with the procedure and have had the opportunity to discuss my condition and treatment options with my physician.

Insurance Information

Insurance Company: [Insurance Company Name]

Policy Number: [Policy Number]

Signature

_____

[Patient's Full Name]

Date: [Today's Date]

If you have any questions regarding this authorization, please contact my healthcare provider at [Provider's Phone Number].