Healthcare Treatment Authorization

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Patient ID: [Insert Patient ID]

To Whom It May Concern,

I, [Insert Your Name], am writing to authorize [Insert Healthcare Provider's Name] to provide long-term care services to the above-named individual. This authorization allows for the necessary treatment and care recommended for [Insert Patient Name] to ensure their health and well-being.

Please find below the details of the authorized treatment:

- Type of Services: [Insert Type of Services]
- Duration of Services: [Insert Duration]
- Start Date: [Insert Start Date]
- End Date: [Insert End Date]

I understand that this authorization is voluntary and that I may revoke it at any time by submitting a written request. A copy of this authorization will remain in the patient's medical record.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title/Relationship to Patient]

[Your Contact Information]