

# Healthcare Treatment Authorization Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Full Name], hereby authorize the outpatient services provided by [Healthcare Provider's Name] at [Facility Name]. This authorization is for the treatment of [specific diagnosis or condition] as per the recommendations from my healthcare provider, Dr. [Provider's Name].

Details of Treatment:

- Type of Service: [Specify Type of Service]
- Duration of Treatment: [Specify Duration]
- Expected Date of Service: [Insert Date]

I understand that this authorization is necessary to proceed with the specified treatment and that I can revoke this authorization at any time by providing written notice.

Please feel free to contact me at [Patient's Phone Number] or [Patient's Email] if you require any further information or documentation.

Thank you for your attention to this matter.

Sincerely,

[Patient's Signature]

[Patient's Printed Name]

[Patient's Address]

[Patient's Date of Birth]