Healthcare Treatment Authorization

Date: [Insert Date]

To: [Provider's Name]
[Provider's Address]
[City, State, Zip Code]

Patient's Name: [Patient's Full Name]
Patient's Address: [Patient's Address]
[City, State, Zip Code]
Patient's Date of Birth: [Date of Birth]

Dear [Provider's Name],

I hereby authorize [Provider's Name] to perform the following specialized medical tests on me:

- [Test 1]
- [Test 2]
- [Test 3]

This authorization is granted for the purpose of diagnosis and treatment options regarding my medical condition. I understand the nature of the tests and any associated risks.

Please feel free to contact me should you require any further information or documentation. Thank you for your attention to this matter.

Sincerely,

[Patient's Full Name]
[Patient's Phone Number]
[Patient's Email Address]