Agreement for Therapeutic Procedure Authorization

Date: **[Insert Date]**

Patient Name: **[Insert Patient Name]**

Patient Address: **[Insert Patient Address]**

Patient Contact Number: **[Insert Patient Contact Number]**

To Whom It May Concern,

I, **[Insert Patient Name]**, hereby authorize **[Insert Therapist/Doctor Name]** to perform the following therapeutic procedure:

[Insert Description of Procedure]

This authorization includes the review of my medical history, necessary pre-procedure evaluations, and the execution of the above-mentioned procedure. I understand the potential risks and benefits associated with this procedure and have had the opportunity to ask questions regarding it.

I also understand that I have the right to withdraw my consent at any time prior to the initiation of the procedure.

By signing below, I acknowledge that I have read and fully understand the details of this authorization.

Patient Signature: _____

Date: _____

Therapist/Doctor Signature: _____

Date: _____

Thank you for your attention to this matter.

Sincerely,

[Insert Patient Name]