Consent for Medical Procedure Authorization

Date: _____

To Whom It May Concern,

I, **[Your Name]**, hereby give my consent for the medical procedure described below:

Procedure Name: _____

Physician's Name: _____

Reason for Procedure: _____

I have been informed about the procedure, including its risks and benefits, and I have had the opportunity to ask questions. I understand that I can withdraw my consent at any time prior to the procedure.

By signing below, I confirm that I consent to the above-mentioned medical procedure.

Signature: _____

Print Name: _____

Relationship to Patient (if applicable): _____

Patient's Name (if different): _____