Consent for Medical Treatment Abroad

Date: _____

To Whom It May Concern,

I, **[Patient's Full Name]**, born on **[Date of Birth]**, residing at **[Patient's Address]**, hereby give my consent for medical treatment to be conducted abroad.

This consent includes the right for my healthcare provider, **[Healthcare Provider's Name]**, and their designated representatives to arrange and facilitate all necessary medical procedures and treatments in **[Country/Location]**.

I understand that the details of the proposed treatment include, but are not limited to:

- **[Description of Treatment/Procedure]**
- **[Expected Risks/Benefits]**
- **[Duration of Treatment]**

I acknowledge that I have had the opportunity to ask questions regarding the proposed treatment and that my questions have been answered to my satisfaction.

By signing this document, I confirm that I am of legal age and that I consent to the outlined medical treatment abroad.

Signature: _____

Name: **[Patient's Name]**

Date: _____

Witness Signature: _____

Name: **[Witness's Name]**

Date: _____