Medical Treatment Verification Letter

Date: [Insert Date]

[Your Name]
[Your Title/Position]
[Name of the Medical Institution]
[Address of the Medical Institution]
[City, State, ZIP Code]
[Phone Number]
[Email Address]

To Whom It May Concern,

This letter is to verify that [Patient's Full Name], born on [Patient's Date of Birth], is under our care and is currently receiving medical treatment at [Name of the Medical Institution]. The nature of the medical condition is as follows:

[Brief Description of the Medical Condition]

As part of their treatment plan, it is necessary for [Patient's Full Name] to pursue ongoing medical care and follow-up consultations. The proposed treatment duration is from [Start Date] to [End Date].

Please feel free to contact our office should you require any additional information or further verification regarding [Patient's Name]'s medical treatment.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Title]
[Name of the Medical Institution]