Medical Treatment Authorization Letter

Date: [Insert Date]

Patient's Name: [Insert Patient's Name]

Patient's Address: [Insert Patient's Address]

Patient's Date of Birth: [Insert DOB]

To Whom It May Concern,

I, [Insert Patient's Name], hereby authorize [Insert Medical Provider's Name] to perform the following diagnostic procedures:

- [Insert Diagnostic Procedure 1]
- [Insert Diagnostic Procedure 2]
- [Insert Additional Procedures if necessary]

This authorization is effective from [Insert Start Date] to [Insert End Date]. I understand that I have the right to revoke this authorization at any time by providing written notice to the above-mentioned provider.

Should you require any further information, please feel free to contact me at [Insert Patient's Phone Number] or [Insert Patient's Email Address].

Sincerely,

[Insert Patient's Signature]

[Insert Printed Name]