Medical Treatment Authorization for Elective Surgery

Date: [Insert Date]

To Whom It May Concern,

I, [Patient Name], hereby authorize [Physician's Name] and [Practice/Hospital Name] to perform the elective surgery of [Type of Surgery] on [Date of Surgery].

This surgery is necessary for my medical condition, and I understand the risks associated with the procedure. I have discussed the details, benefits, and potential complications with my physician, and I consent to the treatment provided.

Please find attached all necessary documentation regarding my medical history and insurance information.

Thank you for your attention to this matter.

Sincerely,

[Patient Signature]
[Patient Name]
[Patient Address]
[Patient Phone Number]
[Patient Email]