Medical Treatment Authorization for Mental Health Services

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], am writing to authorize [Provider's Name] to provide mental health treatment to my [relation, e.g., son/daughter], [Patient's Name], who is [Patient's Age]. This authorization includes, but is not limited to, psychiatric evaluation, therapy sessions, and any necessary follow-up appointments.

This authorization is effective from [Start Date] to [End Date]. I understand that I can revoke this authorization at any time by providing written notice.

Please feel free to contact me at [Your Phone Number] or [Your Email Address] for any further information or clarification.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Address]

[Your Signature]