Medical Treatment Authorization Letter

Date: _____

To Whom It May Concern,

I, [Patient's Name], hereby authorize [Physician's Name] at [Healthcare Facility/Practice Name] to prescribe and administer the necessary medication for my treatment.

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's DOB]
- Address: [Patient's Address]
- Contact Number: [Patient's Contact Number]

Prescribing Physician Information:

- Name: [Physician's Full Name]
- Practice Name: [Healthcare Facility/Practice Name]
- Contact Number: [Physician's Contact Number]

Medication to be prescribed:

- [Name of Medication]
- [Dosage and Instructions]

This authorization remains in effect until [Expiration Date].

Thank you for your assistance.

Sincerely,

_____
[Patient's Signature]

_____
[Patient's Printed Name]