Medical Treatment Authorization Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], residing at [Your Address], hereby authorize medical treatment for my patient:

Patient Name: [Patient's Name]
Date of Birth: [Patient's Date of Birth]
Patient ID: [Patient's ID Number]

This authorization allows the following specialist to provide medical treatment:

Specialist Name: [Specialist's Name]
Specialty: [Specialist's Specialty]
Contact Information: [Specialist's Contact Information]

The purpose of this referral is for [Brief Description of Medical Condition or Reason for Referral].

I understand that the specialist may take necessary actions regarding the diagnosis, treatment, and care of the patient.

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Title or Position]
[Your Contact Information]