Authorization for Changes in Treatment Regimen

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], residing at [Your Address], hereby authorize [Healthcare Provider's Name] to make the following changes to my treatment regimen:

- Current Treatment: [Describe Current Treatment]
- Proposed Changes: [Describe Proposed Changes]
- Effective Date: [Insert Start Date of Changes]

This authorization is granted for the purpose of ensuring the best possible care for my medical condition. I understand that I have the right to revoke this authorization at any time.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

[Your Contact Information]