Consent for Alterations in Medical Treatment

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

To Whom It May Concern,

I, [Insert Patient Name], hereby give my consent for alterations to my medical treatment as discussed with my healthcare provider, [Insert Provider's Name], on [Insert Date of Discussion].

Details of Treatment Alterations:

- [Detail 1]
- [Detail 2]
- [Detail 3]

I understand the nature of these alterations and their potential benefits and risks. I have had the opportunity to ask questions and discuss my concerns regarding this change in my treatment plan.

My consent is given freely and without coercion.

Signature of Patient: _____

Date: _____

Healthcare Provider's Signature: _____

Date: _____