Patient Consent for Treatment Adjustments

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Full Name], hereby give my consent for adjustments to my treatment plan as discussed with my healthcare provider, [Healthcare Provider's Name]. I understand that these adjustments may include, but are not limited to, changes in medication, therapy sessions, or other recommended treatments.

I have been informed about the nature of these adjustments, possible risks, and expected outcomes. I acknowledge that it is my right to ask questions and to understand the reasons behind these treatment modifications.

By signing this document, I confirm that I have had the opportunity to discuss my treatment adjustments and agree to proceed.

Patient Signature: ______________________________

Date: ________________________

Healthcare Provider Signature: ___________________________

Date: ________________________

If necessary, please contact me at [Patient's Phone Number] or [Patient's Email Address] for any further clarifications.

Thank you,

[Patient's Full Name]