MEDICAL AUTHORIZATION LETTER

Date: _____

Dear [Name of Doctor],

I, [Your Name], hereby authorize [Name of Representative], with phone number [Phone of Representative] and relationship [Relationship], to make medical decisions on my behalf during my treatment or in case of an emergency where I am unable to give informed consent.

The authorized person is permitted to:

[Scope of Authorization]

This authorization shall remain valid from [Start Date] until [End Date], unless revoked earlier in writing by me.

Thank you for your attention and cooperation. In case you have any queries, do not hesitate to reach out at [Your Contact Number/Email].

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