**(First-party’s Name)**

(Address)

(City, Zip code)

(Date)

**(Name of Hospital)**

(Address)

(City, Zip code)

To Whom It May Concern:

I**, (*first-party’s name)*,** do hereby authorize **(*name of doctor/clinic)****,* to proceed with the medical treatment and provide the care needed by my **(*state relationship with patient****),* **(*insert name of patient)***, for his/her (***state sickness of the patient****)*. I am fully aware of the complications of the treatment and agree to the terms of the procedure.

Attached herewith is a copy of my **(*name of your valid ID)*** as proof of consent regarding this matter.

For any concerns and questions, you may contact me at **(*insert phone number).***

Sincerely,

**(*signature over printed name)***