*(Name of Appointed Guardian)*
*(Address of Appointed Guardian)*
*(Phone and/or email contact information)(Recipient Name)*
*(Recipient Address)*
*(Recipient Contact Information)(Date)(RE: Medical Treatment Authorization for Name)*

*To Whom It May Concern:*

*I, (Appointed Guardian), am the appointed guardian of (Name). I hereby give consent and authority to (Name, Address, Contact information of Appointed Caregiver) to authorize medical treatment for (Name, Address, Date of Birth of Individual).*

***Medical Information:***

* *(Name) has the following allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *(Name) is on the following medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *Health insurance carrier is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *Health insurance policy number is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*This medical authority treatment letter is granted on this day, (DATE) and will no longer be in effect as of (DATE).*

*This medical treatment authorization letter is necessary as I will be unavailable during the dates stated above.*

*Under no circumstances is (Appointed Guardian) to have access to my financial information.*

*Sincerely,*

*(Signature of Appointed Guardian)*
*(Date Signed)*
*(Typed Name of Appointed Guardian)*
*(Notary Public if Required)*
*(Date)*
*(Typed Name of Witness)*
*(Date)*