MEDICAL PERMISSION LETTER

DATE

[Department]
[Recipient's organization]
[Recipient's Street Address]
[Recipient's City, State, and Zip Code]

or

To whom it may concern

I, [your name], hereby give permission for [name of depandant] to receive medical treatment or evaluation. The purpose of this permission is [insert specific details about the treatment or evaluation].

This permission is valid from [insert date] to [insert date].

In case of concern please contact me at [email] or [phone]

Sincerely,

[signature]
[Your Name]
[Your relationship with dependant]