

CHC Hilltop Medical Clinic

1202 Martin Luther King Jr. Way

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April 28, 2017

Re: *Preferred name (Legal name) Last name*

DOB: *xx/xx/xxxx*

To Whom it May Concern:

I am a provider licensed to practice medicine in the state of Washington. *(Preferred name)* is a patient in my practice. She has a long history of persistent gender dysphoria and has been evaluated for the capacity to provide informed consent. She has no significant uncontrolled medical or mental health conditions. I recommend her for feminizing breast surgery.

Sincerely,

Provider name

License # *XXXXXXX*