

Date: [Insert Date]
Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID/Chart Number: [Insert ID Number]

To: [Insert Doctor/Provider Name]
Facility Name: [Insert Clinic/Hospital Name]
Fax/Email: [Insert Contact Information]

RE: Prescription Update/Refill Request

Dear Dr. [Insert Doctor Last Name],

I am writing to request an update or renewal for the following medication(s) currently prescribed to the patient mentioned above:

- **Medication Name:** [Insert Medication Name]
- **Current Dosage:** [Insert Strength, e.g., 20mg]
- **Frequency:** [Insert How Often Taken, e.g., Once Daily]
- **Reason for Update:** [e.g., Running out of refills / Change in pharmacy / Requesting dosage adjustment]

Please send the updated prescription to the pharmacy listed below:

Pharmacy Name: [Insert Pharmacy Name]
Pharmacy Phone: [Insert Pharmacy Phone]
Pharmacy Address: [Insert Pharmacy Address]

If you require a follow-up appointment or laboratory testing before authorizing this update, please contact me at [Insert Phone Number].

Thank you for your assistance.

Sincerely,

[Your Signature]
[Your Printed Name]
[Relationship to Patient, if applicable]