

Date: [Date]

From (Releasing Pharmacy/Provider):

[Facility Name]

[Address]

[Phone Number]

[Fax Number]

To (Receiving Pharmacy/Provider):

[Facility Name]

[Address]

[Phone Number]

[Fax Number]

Subject: Prescription and Medication Transfer Verification

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Patient ID/Record Number: [ID Number]

To whom it may concern,

This letter serves as formal verification and authorization for the transfer of the following active prescription(s) for the patient listed above:

Medication Name	Strength/Dosage	Directions (Sig)	Refills Remaining	Original Rx Date
[Medication 1]	[Strength]	[Instructions]	[Number]	[Date]
[Medication 2]	[Strength]	[Instructions]	[Number]	[Date]

Transfer Details:

The last fill date for the above medication(s) was [Date]. All relevant clinical documentation and prescription history are attached to this transfer request.

Please update your records accordingly and confirm receipt of this transfer by contacting our office at [Phone Number].

Sincerely,

[Signature]

[Printed Name of Pharmacist/Provider]

[License Number]

[Contact Information]