Date: [Insert Date]

To: [Doctor's Name]
Clinic Name: [Clinic/Facility Name]
Address: [Clinic Address]
Phone: [Clinic Phone Number]

Subject: Prescription Refill and Treatment Continuation for [Patient Name]

Dear Dr. [Doctor's Last Name],

I am writing to request a refill for my current medication(s) to ensure the continuation of my prescribed treatment plan. My current supply is due to run out on [Date].

Medication Details:

- **Medication Name:** [Name of Drug]
- **Dosage:** [e.g., 20mg]
- **Frequency:** [e.g., Once daily]
- **Pharmacy Name:** [Pharmacy Name]
- **Pharmacy Phone:** [Pharmacy Phone Number]

I have been adhering to the treatment as directed and [mention any brief updates, e.g., am experiencing no side effects / would like to discuss my progress during the next visit].

Please let me know if I need to schedule an appointment for an evaluation before this refill can be authorized, or if you can send the prescription directly to my pharmacy.

Thank you for your time and continued care.

Sincerely,

[Your Signature]
[Your Printed Name]
[Date of Birth]
[Your Phone Number]