[Date]

[Physician Name]
[Clinic/Practice Name]
[Address]
[City, State, Zip Code]

RE: Medication Refill Authorization for [Patient Name]
Date of Birth: [Patient DOB]

Dear Dr. [Physician Last Name],

I am writing to request a refill authorization for the following maintenance medication(s):

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

I am currently stable on this treatment and my current supply will be exhausted on [Date]. Please send an electronic prescription or fax the authorization to my pharmacy to ensure there is no interruption in my treatment plan.

If an office visit or blood work is required before this refill can be approved, please contact me at [Your Phone Number] to schedule an appointment.

Thank you for your assistance.

Sincerely,

[Your Signature]
[Your Printed Name]