Date: [Current Date]

To: [Name of New Pharmacy]
Address: [New Pharmacy Address]
Phone Number: [New Pharmacy Phone Number]

RE: Authorization to Transfer Prescriptions

Dear Pharmacist,

I am writing to formally authorize the transfer of my prescription records to your pharmacy, effective immediately. Please contact my current pharmacy to complete the transfer process.

Patient Information:

- **Full Name:** [Patient First and Last Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Phone Number:** [Patient Phone Number]
- **Address:** [Patient Home Address]

Current Pharmacy Information (Transferring From):

- **Pharmacy Name:** [Old Pharmacy Name]
- **Pharmacy Phone:** [Old Pharmacy Phone Number]

Prescriptions to be Transferred:

[List specific prescription names/RX numbers here, or write "All active prescriptions with remaining refills"]

I also authorize [New Pharmacy Name] to contact my healthcare provider(s) if new authorizations or refill extensions are required during this transition.

Thank you for your assistance with this matter.

Sincerely,

[Patient Signature]

[Patient Printed Name]