Date: [Insert Date]

To: [Pharmacy Name / Medical Provider]
Address: [Pharmacy Address]

Subject: Authorization for Emergency Medication Supply

To Whom It May Concern,

This letter serves as formal authorization from **[Clinic Name]** for the emergency release of a temporary medication supply for the patient identified below:

- **Patient Name:** [Patient Full Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Medication Name:** [Name of Medication]
- **Dosage/Strength:** [e.g., 20mg]
- **Quantity Authorized:** [e.g., 3-day supply / 7-day supply]

The patient is currently under our care and requires this emergency supply due to [Reason for Emergency: e.g., delay in prescription renewal / travel loss / clinical urgency]. A full prescription will be forwarded to your facility via [Electronic Transfer / Fax] shortly.

Should you require verification or have any questions regarding this authorization, please contact our office immediately at [Clinic Phone Number].

Thank you for your assistance in ensuring the continuity of care for our patient.

Sincerely,

[Signature of Physician/Authorized Staff]
[Printed Name]
[Title/Position]
[License Number]
[Clinic Name]