

Date: [Insert Date]

To: [Pharmacist Name / Pharmacy Name]

Address: [Pharmacy Address]

Subject: Emergency Medication Dispense Authorization

To whom it may concern,

I, **[Physician Name]**, license number **[License Number]**, hereby authorize an emergency dispense of the following medication for my patient:

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medication Name: [Name of Drug]

Dosage/Strength: [e.g., 20mg]

Quantity Authorized: [e.g., 3-day supply / 1 original container]

This authorization is issued due to an emergency situation where the patient is unable to obtain a standard prescription and requires an immediate supply to prevent interruption of treatment for **[Medical Condition]**.

I confirm that I will provide a formal follow-up prescription to this pharmacy within **[Number]** hours/days as per local regulatory requirements.

If you have any questions, please contact my office immediately at **[Phone Number]**.

Sincerely,

[Signature]

[Physician Printed Name]

[Clinic/Hospital Name]

[Contact Email]