Date: [Insert Date]

To: [Pharmacist Name or Pharmacy Name]
Pharmacy Address: [Insert Pharmacy Address]

RE: Emergency Prescription Supply Authorization

To whom it may concern,

I am writing to formally authorize an emergency supply of the following medication(s) for the patient listed below:

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Patient Date of Birth]
Medication Name: [Insert Medication Name]
Dosage: [Insert Dosage, e.g., 20mg]
Frequency: [Insert Frequency, e.g., Once daily]

The patient is currently unable to obtain a standard refill due to the following emergency circumstances: [Insert Brief Reason, e.g., Travel delay, lost medication, or clinic closure].

I am the prescribing physician for this patient. I authorize a [Insert Number, e.g., 3-day or 7-day] emergency supply to ensure there is no lapse in treatment until a full prescription can be processed.

Please contact my office at [Insert Phone Number] if you require further verification.

Sincerely,

[Physician Signature]

Physician Name: [Insert Printed Name]
Medical License Number: [Insert License Number]
NPI Number: [Insert NPI Number]
Clinic Name: [Insert Clinic Name]