

Date: [Insert Date]

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

Address: [Pharmacy/Provider Address]

Subject: Temporary Emergency Medication Authorization

To Whom It May Concern,

I, [Your Full Name], am writing to formally authorize a temporary emergency supply of the following medication(s) for [Patient Full Name], born on [Patient Date of Birth].

Due to [Reason for Emergency: e.g., travel delay, natural disaster, loss of medication, or inability to reach primary physician], the patient is currently unable to obtain a standard refill and requires an emergency supply to prevent a lapse in treatment.

Medication Details:

- **Medication Name:** [Name of Medicine]
- **Dosage:** [e.g., 20mg]
- **Frequency:** [e.g., Once daily]
- **Prescribing Physician:** [Doctor's Name]
- **Physician Phone:** [Doctor's Phone Number]

I am requesting a [Number of Days, e.g., 3-day or 7-day] emergency supply. I understand that this is a temporary measure and I will coordinate with the prescribing physician for a full refill as soon as possible.

If you need to verify this request, please contact me immediately at [Your Phone Number] or [Your Email Address].

Thank you for your immediate assistance in this urgent matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Relationship to Patient, if applicable]