

**Date:** [Insert Date]

**To:** [Name of Pharmacy/Medical Provider]

**From:** [Physician Name/Clinic Name]

## **Subject: Authorization for Standby Emergency Medication Supply**

To Whom It May Concern,

This letter serves as formal authorization for **[Patient Full Name]**, Date of Birth: **[DOB]**, to carry and maintain a standby emergency supply of the following medication(s):

- **Medication Name:** [Insert Drug Name]
- **Dosage:** [Insert Dosage, e.g., 500mg]
- **Quantity Authorized:** [Insert Quantity]
- **Indications for Use:** [e.g., Acute flare-up, travel emergency, or anaphylaxis]

The patient has been educated on the proper administration, storage, and indications for this medication. This supply is intended for emergency use only when immediate access to a healthcare facility may be delayed.

**Physician Instructions:** [Insert specific instructions for the patient or pharmacist]

If you have any questions regarding this authorization, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]

[Clinic/Hospital Name]