Date: [Date]

To: [Pharmacist Name/Pharmacy Name]
Address: [Pharmacy Address]
Phone: [Pharmacy Phone Number]

RE: Patient Specific Controlled Substance Authorization

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient Address: [Patient Address]

To Whom It May Concern,

This letter serves as formal authorization for the aforementioned patient to receive the following controlled substance medication as prescribed by this office:

- **Medication Name:** [Medication Name and Strength]
- **Dosage Instructions:** [Instructions, e.g., Take one tablet daily]
- **Quantity:** [Total Quantity]
- **Refills:** [Number of Refills authorized, if any]
- **ICD-10 Diagnosis Code:** [Diagnosis Code]

I confirm that I have a valid patient-provider relationship with this individual and that this prescription is issued for a legitimate medical purpose. I have reviewed the patient's history on the Prescription Monitoring Program (PMP/PDMP) as required by state law.

In the event that the patient is unable to pick up this medication personally, I authorize the following individual(s) to act as their agent for pickup:

Authorized Representative: [Representative Name]
Relationship to Patient: [Relationship]

If you have any questions or require further verification, please contact my office directly at [Office Phone Number].

Sincerely,

[Physician Signature]
Prescriber Name: [Name and Title]
DEA Number: [DEA Number]
NPI Number: [NPI Number]
Clinic Name: [Practice/Clinic Name]