Date: [Date]

To: [Pharmacist Name/Pharmacy Name]
Address: [Pharmacy Address]
City, State, Zip: [City, State, Zip]

RE: REVOCATION OF PRESCRIPTION AUTHORIZATION

Patient Name: [Patient Full Name]
Patient Date of Birth: [DOB]
Prescriber Name: [Doctor Name]
DEA Number: [DEA Number]

Dear Pharmacist,

This letter serves as formal notification to revoke and cancel all active prescriptions and refills for controlled substances previously authorized by me for the patient listed above, effective immediately.

Please invalidate any remaining refills for the following medication(s):

- [Medication Name and Strength] - [Rx Number if known]
- [Medication Name and Strength] - [Rx Number if known]

I request that you update your records to ensure no further dispensing of these controlled substances occurs under my authorization for this patient. If the patient attempts to fill these prescriptions, please inform them that the authorization has been rescinded by the prescribing physician.

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

Sincerely,

[Prescriber Signature]
[Prescriber Printed Name]
[Practice/Clinic Name]