Date: [Date]

To: [Pharmacy Name]
Pharmacy Address: [Pharmacy Street Address, City, State, Zip]

RE: AUTHORIZATION FOR DISPENSING COMPOUNDED MEDICATION

Patient Name: [Child's Full Name]
Date of Birth: [MM/DD/YYYY]
Parent/Guardian Name: [Name of Parent or Legal Guardian]

To Whom It May Concern,

I, [Parent/Guardian Name], hereby authorize [Pharmacy Name] to prepare and dispense the following compounded medication for my child, [Child's Name], as prescribed by Dr. [Physician Name]:

Medication Name: [Name of Medication/Formula]
Strength/Concentration: [e.g., 5mg/mL]
Dosage Form: [e.g., Oral Suspension, Topical Cream]

I acknowledge and understand the following:

- This medication is a customized compound and is not a commercially available FDA-approved product.
- The pharmacy has explained the clinical necessity of this specific formulation for my child's treatment.
- I consent to the use of specific flavors or bases as indicated in the prescription to ensure patient compliance.

I authorize the pharmacy to contact my child's prescribing physician if any clarifications regarding the formulation are required.

This authorization shall remain in effect for the duration of the current prescription and any subsequent refills unless revoked by me in writing.

Sincerely,

____
Signature of Parent/Legal Guardian

Phone Number: [Your Phone Number]
Email Address: [Your Email Address]