

Date: [Insert Date]

To:

[Pharmacy Name]

[Pharmacy Address]

[City, State, Zip Code]

Subject: Authorization for Recurring Mail-Order Prescription Delivery

To Whom It May Concern,

I, [Your Full Name], date of birth [Your Date of Birth], hereby authorize [Pharmacy Name] to establish a recurring mail-order delivery service for my prescriptions.

Patient Information:

Patient ID/Member Number: [Insert Number]

Phone Number: [Insert Phone Number]

Email Address: [Insert Email Address]

Shipping Address:

[Street Address]

[City, State, Zip Code]

Prescription Details:

I authorize the recurring delivery of the following medication(s):

1. [Medication Name and Dosage]

2. [Medication Name and Dosage]

[Add more as needed or state "All active prescriptions"]

Payment Authorization:

I authorize [Pharmacy Name] to charge the payment method on file for any applicable co-pays, deductibles, or shipping fees associated with these deliveries.

Authorization Period:

This authorization shall remain in effect until I provide written notice of cancellation or until the expiration of the current prescriptions.

By signing below, I acknowledge that I am responsible for notifying the pharmacy of any changes to my shipping address, contact information, or insurance coverage.

Sincerely,

[Signature]

[Printed Name]