

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Phone Number]  
[Email Address]  
[Date]

[Pharmacy Name]  
[Pharmacy Mail-Order Department]  
[Pharmacy Address]  
[City, State, Zip Code]

**Subject: Cancellation of Mail-Order Prescription Delivery Authorization**

Dear Pharmacy Department,

I am writing to formally request the immediate cancellation of my authorization for mail-order prescription delivery services for the following account:

- **Member Name:** [Your Full Name]
- **Member ID / Account Number:** [Your ID Number]
- **Date of Birth:** [Your Date of Birth]

Effective [Date], please stop all automatic refills and shipments to my address. I also request that you remove any credit card or payment information associated with automatic billing for mail-order deliveries from my profile.

I will hereafter obtain my prescriptions through a local retail pharmacy or will contact you manually should I require mail services in the future. Please provide a written confirmation via mail or email that this cancellation has been processed.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]