

[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]

RE: Authorization for Mail-Order Prescription Delivery

To Whom It May Concern,

I am writing to formally authorize [Pharmacy Name] to provide home delivery services for my maintenance medications. I have been diagnosed with a chronic condition that requires long-term medication management, and I request that my prescriptions be transitioned to your mail-order delivery system.

Patient Information:

Full Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID / Policy Number: [ID Number]
Prescribing Physician: [Doctor Name]

Authorization Details:

- I authorize the delivery of all current and future maintenance prescriptions to my address listed above.
- I authorize [Pharmacy Name] to charge the credit card ending in [Last 4 Digits] on file for any applicable co-pays or shipping fees.
- I confirm that my delivery location is a secure address for the receipt of medications.

This authorization shall remain in effect until I provide written notice of cancellation. Please contact me at [Phone Number] if you require any further documentation to process this request.

Thank you for your assistance in managing my ongoing healthcare needs.

Sincerely,

[Signature]
[Printed Name]