Date: [Date]

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

Subject: Out-of-State Mail-Order Prescription Delivery Authorization

To Whom It May Concern,

I, [Patient Full Name], born on [Patient Date of Birth], hereby authorize [Pharmacy Name] to fill and mail my prescriptions to an out-of-state address.

Please deliver my medications to the following shipping address:

[Recipient Name]
[Street Address]
[City, State, Zip Code]

Prescription Information:

- Prescription Number(s): [List Rx Numbers or write "All Current Medications"]
- Prescribing Doctor: [Doctor Name]

I confirm that I will be at this location to receive the delivery and understand any shipping regulations associated with receiving medications across state lines. Please apply the charges to my payment method on file ending in [Last 4 Digits of Card].

If there are any issues regarding this request, please contact me at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Printed Name]