Date: [Insert Date]

To: [Recipient Name/Facility Name]
From: [Physician/Provider Name]
Subject: Authorization for As-Needed (PRN) Pain Management

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

This letter serves as formal authorization for the administration of as-needed (PRN) pain medication for the patient listed above. Please follow the specific instructions provided below:

- **Medication Name:** [Insert Medication Name]
- **Dosage:** [Insert Dose, e.g., 500mg]
- **Route:** [e.g., Oral]
- **Frequency:** Every [Number] hours as needed for pain.
- **Maximum Daily Dose:** Do not exceed [Number] doses in 24 hours.
- **Indication:** [e.g., Mild to moderate pain, post-operative recovery]

Special Instructions:
[Insert any additional notes, such as "Take with food" or "Notify provider if pain persists after 3 doses"]

This authorization is valid from [Start Date] until [End Date/Further Notice].

If there are any questions regarding this protocol, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Credentials]
[Medical License Number]
[Clinic/Hospital Name]