Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Prescription Name: [Medication Name and Dosage]

Subject: Patient Agreement for Replacement of Lost Prescription

To [Clinic/Provider Name],

I, [Patient Full Name], am requesting a one-time replacement for the prescription mentioned above, which was lost or destroyed on [Date of Loss].

By signing this letter, I acknowledge and agree to the following terms:

- I confirm that the original prescription has been lost and has not been filled, or if filled, the medication is no longer in my possession.
- I understand that [Clinic/Provider Name] tracks replacement requests and that frequent requests for lost prescriptions may result in a review of my treatment plan or a refusal of future replacements.
- I understand that my insurance provider may not cover the cost of a replacement fill, and I accept full financial responsibility for any out-of-pocket costs.
- I agree to implement better safeguards to prevent the loss of my medications in the future.
- For controlled substances: I understand that a police report may be required for future replacement requests involving theft.

I attest that the information provided above is true and accurate.

_____
Patient Signature

_____
Date Signed

For Office Use Only:

Authorized by: _____
Date Authorized: _____
Pharmacy Notified: [ ] Yes [ ] No