Date: [Insert Date]

To: [Pharmacist Name or Pharmacy Name]
Address: [Pharmacy Address]
Phone: [Pharmacy Phone Number]

Subject: Authorization for Replacement of Lost Prescription

To Whom It May Concern,

I, [Medical Director Name], in my capacity as Medical Director at [Facility/Clinic Name], hereby authorize the replacement of a lost prescription for the following patient:

- **Patient Name:** [Full Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Medication Name:** [Medication Name and Strength]
- **Original Date of Issue:** [Date]

The patient has reported the original prescription as [lost/stolen/destroyed]. After reviewing the patient's medical records and confirming the clinical necessity for uninterrupted treatment, I validate that a one-time replacement is authorized.

Please dispense the replacement as per the original instructions. All previous authorizations for the lost prescription should be voided to prevent duplicate dispensing.

If you require further verification, please contact our office at [Office Phone Number].

Sincerely,

[Signature]
[Medical Director Name, Degree]
Medical License Number: [License Number]
NPI Number: [NPI Number]
[Facility/Clinic Name]