

[Date]

[Doctor's Name]

[Clinic/Hospital Name]

[Clinic Address]

[City, State, Zip Code]

RE: Prescription Refill Authorization for [Patient Name]

Dear Dr. [Doctor's Last Name],

I am writing to request a refill authorization for the following medication(s):

- **Medication Name:** [Name of Medicine]
- **Dosage:** [e.g., 20mg]
- **Frequency:** [e.g., Once daily]
- **Quantity Requested:** [e.g., 30-day or 90-day supply]

My date of birth is [Patient Date of Birth]. These medications are necessary for the ongoing treatment of [Condition Name].

Please send the electronic prescription to my preferred pharmacy:

Pharmacy Name: [Pharmacy Name]

Pharmacy Phone: [Pharmacy Phone Number]

Pharmacy Address: [Pharmacy Address/Location]

If an office visit is required before this refill can be approved, or if you have any questions, please contact me at [Your Phone Number].

Thank you for your time and assistance.

Sincerely,

[Your Signature]

[Your Printed Name]