# Prescription Replacement Policy Clarification

Date: [Insert Date]

[Your Name]

[Your Position]

[Your Company/Organization]

[Your Address]

[City, State, Zip Code]

Email: [Your Email]

Phone: [Your Phone Number]

## To Whom It May Concern,

This letter serves to clarify our policy regarding the replacement of prescriptions. We understand that circumstances may arise where a prescription needs to be replaced due to various reasons such as loss, theft, or damage.

According to our policy, prescriptions can be replaced under the following conditions:

- The patient must provide a valid reason for the replacement request.
- The original prescription should not have been filled or partially filled.
- A formal request must be submitted to our office via email or fax.

All requests will be reviewed on a case-by-case basis. It is essential to maintain open communication during this process to ensure a timely resolution.

If you have any questions or need further assistance, please do not hesitate to contact us.

Sincerely,

[Your Name]

[Your Position]

[Your Company/Organization]