Medication Refill Request

Date: [Insert Date]

To: [Doctor's Name]

[Doctor's Office/Clinic Name]

[Office Address]

Dear [Doctor's Name],

I hope this message finds you well. I am writing to request a refill for my medication prescribed for allergy treatment. My details are as follows:

Patient Name: [Your Name]

Date of Birth: [Your DOB]

Medication Name: [Medication Name]

Dosage: [Dosage Instructions]

Pharmacy Name: [Pharmacy Name]

Pharmacy Phone Number: [Pharmacy Phone Number]

I would appreciate it if you could authorize this refill at your earliest convenience. Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Contact Information]