Prescription Refill Request

Date: [Insert Date]

To: [Pharmacy Name]

Address: [Pharmacy Address]

Phone: [Pharmacy Phone Number]

Dear [Pharmacist's Name],

I hope this message finds you well. I am writing to request a refill of my prescription for cholesterol-lowering medication.

Patient Name: [Your Name]
Date of Birth: [Your Date of Birth]
Medication Name: [Medication Name]
Dosage: [Dosage Information]
Prescription Number: [Prescription Number]

Please let me know if you need any additional information to process this refill. Thank you for your assistance.

Sincerely,
[Your Name]
[Your Contact Information]