Prescription Refill Authorization

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID Number]

Date: [Date]

To:
[Healthcare Provider's Name]
[Healthcare Provider's Address]

Dear [Healthcare Provider's Name],

I am writing to request a refill for the prescription medication listed below:

- **Medication Name:** [Medication Name]
- **Dosage:** [Dosage]
- **Frequency:** [Frequency of Use]
- **Original Prescription Date:** [Original Date]
- **Refills Remaining:** [Number of Refills Remaining]

Due to [brief reason for refill authorization such as "the ongoing treatment of my condition"], I would appreciate it if you could authorize a refill as soon as possible.

Thank you for your prompt attention to this matter. If you need any further information, please feel free to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Full Name]
[Your Address]
[Your Phone Number]