Prescription Transfer Authorization

Date: [Insert Date]

To: [Receiving Pharmacy Name]

Address: [Receiving Pharmacy Address]

Dear [Receiving Pharmacy's Pharmacist Name],

I, [Patient's Full Name], authorize the transfer of my prescription(s) from [Current Pharmacy Name] to [Receiving Pharmacy Name]. Below are the details of my prescription:

- **Patient Name:** [Patient's Full Name]
- **Patient DOB:** [Patient's Date of Birth]
- **Prescription Number:** [Prescription Number]
- **Medication Name:** [Medication Name]
- **Dosage:** [Dosage]
- **Quantity:** [Quantity]
- **Refills Remaining:** [Refills Remaining]

I understand that this authorization allows the above-mentioned pharmacy to transfer my prescription information and provide me with the medication. Please process this transfer at your earliest convenience.

Thank you for your assistance.

Sincerely,

[Patient's Signature]

[Patient's Printed Name]

[Patient's Phone Number]