PRESCRIPTION REFILL REQUEST FORM

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Prescription Information:

Medication Name: _____

Dosage (e.g., 10 mg): _____

Quantity: _____

Refills Authorized: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Prescriber Information:

Prescriber Full Name: _____

License Number: _____

Office Phone Number: _____

Office Address: _____

Authorization and Acknowledgment:

I hereby authorize the pharmacy named above to refill the prescription listed above as per the prescriber's authorization. I understand that this request is subject to review and approval by my healthcare provider and the pharmacy. I acknowledge that I am responsible for verifying the accuracy of this request and for any costs associated with the medication refill.

Patient Signature: _____

Date Signed: _____

For Pharmacy Use Only:

Refill request reviewed by: _____ Date: _____ Time: _____ Refill Approved: ■ Yes ■ No Comments: _____

_____

Patient's Signature

Signature: _____

Date: _____

Prescriber's Signature

Signature: _____

Date: _____