[Your Name]
[Your Title]
[Your Medical Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Patient's Name]
[Patient's Address]
[City, State, Zip Code]

Dear [Patient's Name],

I am writing to confirm your request for a prescription refill for [Medication Name], prescribed for [Condition].

Please note the following details:

- Medication: [Medication Name]
- Dosage: [Dosage Amount]
- Quantity: [Amount to be prescribed]
- Refill Instructions: [Number of refills granted]

You can pick up your prescription at [Pharmacy Name] located at [Pharmacy Address] or request it through your preferred pharmacy. If you have any questions or need further assistance, please do not hesitate to contact my office.

Sincerely,

[Your Name]
[Your Title]
[Your Medical Practice Name]