[Your Name]
[Your Title/Position]
[Your Practice/Facility Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Patient's Name]
[Patient's Address]
[City, State, Zip Code]
Dear [Patient's Name],
Prescription:
[Medication Name]
[Dosage]
[Quantity]
[Instructions for Use]
Refills: [Number of Refills]
Please feel free to contact my office if you have any questions or need further assistance.
Sincerely,
[Your Signature]
[Your Printed Name]
[Your Medical License Number]

[Optional: Other Information or Instructions]