[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Pharmacy Name]
[Pharmacy Address]
[City, State, Zip Code]
Subject: Authorization for Vyvanse Prescription
Dear [Pharmacy Manager's Name],
I, [Your Full Name], hereby grant permission for [Pharmacist's Name or Pharmacy Staff] at [Pharmacy Name] to act on my behalf regarding the authorization and processing of my Vyvanse prescription.
Patient Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Prescription Number: [Prescription Number]
Doctor's Name: [Doctor's Name]
Doctor's Contact: [Doctor's Phone Number]
I understand that this authorization is necessary for the continuation of my medication and care. Please do not hesitate to contact me at the number provided above should you need any further information.
Thank you for your assistance and support.
Sincerely,
[Your Signature (if sending a physical copy)]
[Your Printed Name]