(Date of Letter)

(Pharmacy/Care Provider)

(Street Address)

(City, State and Zip Code)

RE: Pharmaceutical Update

Attn: Pharmacy

Dear Pharmacy:

From the day of day of

(month/year), until the (month/year),

(name of individual) received certain medication from a prescription for various medicines that were supplied by your pharmacy. Kindly provide a complete list of all pharmaceuticals prescribed and all prescriptions filled through your pharmacy for the above-named individual. In this regard, please include the specific name of the pharmaceuticals, the recommended dosage and the amount of medication that was provided. Also indicate the precise dates on which the pharmaceuticals were provided. This information is respectfully requested in order for me to complete the medical file relative to (name of individual who was the recipient of the pharmaceuticals). Should you have any specific questions regarding this request, please do not hesitate to contact the undersigned.

Thank you for your assistance.

Very truly yours,

(Signature)

(Address)

(City, State and Zip Code)

(Phone Number)

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