Rx Refill Request

We will be happy to help you with your prescription medication needs.
Prescription refills are subject to Physician approval.
Prescriptions will be considered for refill ONLY if you have been seen in by Dr. Matlick within the last 6 months.

Name: ________________________________ Date: [ ]

Date of Birth: ________________________________

e-mail: ________________________________

Contact phone number: ( ) -

Requested Medication: ________________________________

Requested Medication: ________________________________

Requested Medication: ________________________________

☐ Brand Name Requested ☐ Generic at Physician's discretion

(Please understand that your Rx plan may force a substitution despite your request, or Dr's. recommendation)

Pharmacy: (name and location) ________________________________

Pharmacy Phone # - ( ) -