PRESCRIPTION (RX) RENEWALS

A renewal is for the ***EXACT* RX** you previously received, with **NO** changes of any kind. If anything has changed, you must speak directly to Dr. Hertz.

The most efficient way to get a renewal is to call your pharmacy and ask them to electronically transmit the request to Dr. Hertz. Once received, allow 2 BUSINESS days for processing; then you may call the pharmacy **(*NOT Dr. Hertz*)** to find out if your RX is ready for pick-up. Please do not duplicate your request in writing or by phone. You do not have to let Dr. Hertz know that your pharmacy is requesting a renewal. If your pharmacy will not extend this courtesy to you, you may send a renewal form to the office.

RX renewal forms may be downloaded from *stanleyhertzmd.com* or picked up in the waiting room. They may be emailed to *appts@stanleyhertzmd.com*, faxed to (516) 484-2864 or mailed at least **10 days before** you will run out of medication.

All renewal requests must be legible and include:

Patient name
Date of birth
Name of medication, brand or generic
Dosage
How many times you take it per day
30, 60, or 90 day supply
Name, address and **zipcode** of pharmacy

INCOMPLETE REQUESTS WILL NOT BE PROCESSED

Stanley M. Hertz, M.D
55 Fern Drive
Roslyn, NY 11576-2201
Tel: (516) 484-6366
Fax: (516) 484-2864
appts@stanleyhertzmd.com

PRESCRIPTION RENEWAL FORM

Please submit this form 10 days before you need a renewal. Your prescription will be renewed only if you have seen Dr. Hertz in the past 3 months. If you have not seen Dr. Hertz in the past three months, please call the office to make an appointment.

The information requested on this form may be submitted by mail, e-mail or fax.

Your prescription will be sent electronically to your pharmacy or mail order service.

INCOMPLETE REQUESTS WILL NOT BE PROCESSED

PLEASE PRINT

PATIENT NAME_____DATE OF BIRTH_____

MEDICATION NAME_____

DOSAGE _____

DIRECTIONS (HOW MANY TIMES PER DAY)_____

30 DAY SUPPLY_____60 DAY SUPPLY_____ 90 DAY SUPPLY_____

PHARMACY OR MAIL ORDER SERVICE NAME_____

PHARMACY ADDRESS_____

PHARMACY ZIPCODE_____