Pharmacy Pick-Up Authorization Document

I, _____ (Patient Name), hereby authorize _____ (Authorized Person's Name), to pick up my prescription medications from the pharmacy listed below on my behalf.

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Phone Number: _____

Authorized Person Details

Full Name: _____

Relationship to Patient: _____

Patient Details

Full Name: _____

Date of Birth: _____

Authorization Period

From: _____ To: _____

Signature

Patient Signature: _____

Date: _____