Representative Medication Pickup Authorization

Patient Details

Full Name:

Date of Birth:

Patient ID/Number:

Medication Details

Medication Name:

Dosage/Strength:

Quantity:

Representative Details

Representative Name:

Relationship to Patient:

Contact Number:

ID Type & Number:

Authorization Statement

I hereby authorize the above-named representative to pick up my prescribed medication on my behalf.

Patient Signature:

Date:

Representative Signature:

Date: