# Third-Party Pharmacy Pickup Consent

I hereby authorize the individual named below to pick up my prescription medications on my behalf from the pharmacy.

Patient Name:

Date of Birth:

Authorized Person's Name:

Relationship to Patient:

Prescription(s) to be Picked Up:

Date:

Patient Signature:

By signing above, I acknowledge that the individual named is authorized to pick up my prescriptions and that I have given my consent to the pharmacy to release my medication(s) as specified.