

# Authorized Person Medication Collection Document

I, the undersigned, hereby authorize the person named below to collect my prescribed medication on my behalf.

## Patient Details

Patient Name:

Patient ID / Number:

## Authorized Person Details

Authorized Person Name:

Authorized Person ID / Passport Number:

## Medication Details

Medication Name:

## Authorization Period

From:

To:

## Signature

Patient Signature:

Date: