Authorized Representative Medication Pick-Up Letter

Date: _____

To Whom It May Concern,

I, _____, authorize _____ to pick up my prescription medications on my behalf from _____ pharmacy.

My details are as follows:
Full Name: _____
Date of Birth: _____
Address: _____

Authorized Representative details:
Full Name: _____
Relationship: _____
Phone Number: _____

This authorization is valid for the following period: _____ to _____.

Thank you for your assistance.

Sincerely,
Signature: _____
Printed Name: _____
Date: _____