Pharmaceutical Pick-Up Authorization Letter

Date: _____

To Whom It May Concern,

I, [Your Name], authorize [Caregiver's Name], who is my [relationship, e.g., son, daughter, caregiver], to pick up my prescribed medications on my behalf from [Pharmacy Name] located at [Pharmacy Address].

Details of the prescription are as follows:

- Patient Name: [Patient's Name]
- Prescription Number: [Prescription Number]
- Medications: [List of Medications]

This authorization is valid until [End Date or State "until further notice"].

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Phone Number]

[Your Address]