Pharmaceutical Pick-Up Authorization Letter

Date: __________________

To Whom It May Concern,

I, __________________________ (Your Name), hereby authorize __________________________ (Designated Representative's Name) to pick up my pharmaceutical prescriptions on my behalf from __________________________ (Pharmacy Name). My prescription details are as follows:

Prescription Number: __________________
Patient Name: __________________________
Date of Birth: _________________________

This authorization is valid for the duration of __________________ (Time Period) from the date signed below.

Thank you for your assistance in this matter.

Best Regards,

____
(Your Signature)

____
(Your Printed Name)

____
(Your Contact Information)