

Pharmaceutical Pick-Up Authorization

Date: [Insert Date]

To Whom It May Concern,

This letter serves as authorization for [Authorized Person's Name] to pick up my prescribed medication on my behalf from [Pharmacy Name].

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Insurance Provider: [Insurance Provider Name]
- Policy Number: [Policy Number]

I give my full consent for the release of my medication to the authorized person mentioned above. Please feel free to contact me at [Patient's Phone Number] should you require any further information or verification.

Thank you for your assistance.

Best regards,

[Patient's Signature]

[Patient's Printed Name]

[Patient's Address]