Pharmaceutical Pick-Up Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], authorize [Authorized Person's Full Name] to pick up my pharmaceutical prescriptions on my behalf from [Pharmacy Name]. My details are as follows:

- **Patient Name:** [Your Full Name]
- **Patient Date of Birth:** [Your Date of Birth]
- **Prescription Number:** [Insert Prescription Number]
- **Contact Number:** [Your Contact Number]

This authorization is valid for the following dates: [Start Date] to [End Date].

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Address]

[Your Contact Information]