Pharmaceutical Pick-Up Authorization

Date: _____

To whom it may concern,

I, **[Your Name]**, hereby authorize **[Authorized Person's Name]** to pick up my prescription medications on my behalf from **[Pharmacy Name]**.

Please find my details below:

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

This authorization is valid for the date mentioned above and should be treated as a formal request for the release of my medications.

Thank you for your cooperation.

Sincerely,

[Your Signature]
[Your Printed Name]