

# Pharmaceutical Pick-Up Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Full Name], hereby authorize [Authorized Person's Full Name] to pick up my prescribed medication from [Pharmacy Name] located at [Pharmacy Address]. This authorization is for the following urgent medications:

- Medication Name 1: [Dosage]
- Medication Name 2: [Dosage]
- Medication Name 3: [Dosage]

This authorization is valid from [Start Date] to [End Date]. Please feel free to contact me at [Patient's Phone Number] should you have any questions regarding this authorization.

Thank you for your assistance.

Sincerely,

[Patient's Signature]

[Patient's Full Name]

[Patient's Address]

[Patient's Phone Number]