**Prescription Pick-up Authorization**

If you would like to give consent for another individual to pick up your prescriptions or documentations, please provide that name below:

I give consent for my provider to discuss my medical care with the persons listed below.

Name: Relationship:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Authorized Representative must present valid photo ID upon pick up*)

Name: Relationship:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (*Authorized Representative must present valid photo ID upon pick up*)