Prescription Pick-up Authorization

Patient name: _____

Date of birth: _____ Account #: _____

I, _____, hereby authorize the individual(s)

listed below to pick up my prescription(s) for me at Family Health Medical Services:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

I understand that my agent/representative must provide valid photo identification each time he/she picks up my prescription(s). This authorization will remain active until I revoke it by contacting the staff at Family Health Medical Services.

_____ _____
Patient signature Date

STATE OF _____
COUNTY OF _____

On this, the_____day of _____, 20____, before me a notary public, the undersigned officer, personally appeared_____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that (s)he executed the same for the purposes therein contained.

(SEAL)

_____
Notary Public