

AUTHORIZATION TO PICK-UP PRESCRIPTIONS

Patient: _____

Date: _____

People Approved To Pick Up Prescriptions :	Relationship
1. _____	_____
2. _____	_____

I authorize the above people to pick up my prescriptions from the Pain Management Clinic in the event that I am unable to pick my prescriptions up in person.

Patient Signature: _____

Witness Signature: _____

Date: _____