Authorization to Pick Up Prescriptions

FORM 107 - R180917

I, (YOUR NAME) _____ , THE LEGAL PARENT/GUARDIAN OF THE CHILD(REN) , HEREBY AUTHORIZE THE INDIVIDUAL(S) DESIGNATED BELOW AS "AUTHORIZED INDIVIDUAL" TO PICK UP PRESCRIPTIONS FOR MY CHILD(REN) AT SALEM PEDIATRIC CLINIC IN MY ABSENCE. THIS DOES NOT AUTHORIZE THE INDIVIDUAL(S) TO REQUEST PRESCRIPTIONS WITHOUT MY CONSENT. THE INDIVIDUAL(S) WILL BE PREPARED TO SHOW PHOTO IDENTIFICATION AND SIGN FOR THE PRESCRIPTION WHEN ARRIVING AT THE CLINIC. I CAN REVOKE THIS AUTHORIZATION AT ANY TIME, BUT MUST LET SALEM PEDIATRIC CLINIC KNOW, IN WRITING, OF ANY CHANGES TO THE AUTHORIZATION OF THE INDIVIDUAL(S).

Signed by _____ **Date** _____

AUTHORIZED INDIVIDUALS

Authorized Individual's Full Name	**Relationship to child(ren)**
1	
2	
3	
4	
5	
6	
7	
8	

CHILDREN

Child's Full Name	**Date of Birth**
1	
2	
3	
4	
5	
6	
7	
8	

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