

EXPIRED MEDICATION HANDLING AUTHORIZATION LETTER

Date: [Insert Date]

TO: [Name of Recipient/Organization]

ADDRESS: [Insert Address]

RE: Authorization for the Disposal/Handling of Expired Medications

To Whom It May Concern,

I, [Your Full Name], hereby authorize [Name of Authorized Person or Company] to act on my behalf regarding the collection, transportation, and disposal of expired medications currently held at [Location/Facility Name].

The authorized party is permitted to handle the following medications/supplies:

- [Description/List of Medication 1]
- [Description/List of Medication 2]
- [Description/List of Medication 3]

This authorization is granted to ensure that all expired medications are disposed of in accordance with local environmental and health safety regulations. I confirm that [Name of Authorized Person/Company] has the authority to sign any necessary documentation required by the disposal facility or regulatory agencies.

This authorization is valid from [Start Date] until [End Date/Completion of Disposal].

If you require further verification, please contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Signature]

[Printed Name]

[Title/Position, if applicable]