Date: [Date]

To: [Pharmacy Name]
Address: [Pharmacy Address]
Phone: [Pharmacy Phone Number]

RE: Authorization for Controlled Substance Pickup

To the Pharmacist,

I, **[Patient Full Name]**, date of birth **[Patient Date of Birth]**, hereby authorize the individual named below to pick up my controlled substance prescriptions from your pharmacy on my behalf.

Authorized Individual Information:

- **Full Name:** [Authorized Person's Name]
- **Relationship to Patient:** [e.g., Spouse, Parent, Caregiver]
- **Identification Type:** [e.g., Driver's License/State ID]

This authorization is valid for:

[ ] This one-time pickup only.
[ ] All pickups until [Expiration Date].
[ ] Indefinitely until revoked in writing.

I understand that the authorized individual must present a valid government-issued photo ID at the time of pickup. I assume full responsibility for the medication once it has been released to the person named above.

If you need to verify this authorization, please contact me at **[Patient Phone Number]**.

Sincerely,

_____
[Patient Signature]

[Patient Printed Name]