Date: [Date]

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

RE: Authorization for Mail-Order Delivery of Controlled Substances

To Whom It May Concern,

I, [Patient Full Name], born on [Date of Birth], hereby authorize [Pharmacy Name] to deliver my prescribed controlled substance medications via mail-order to the shipping address listed below:

[Street Address]
[City, State, Zip Code]

Prescription Details:

- **Medication Name:** [Medication Name]
- **Strength/Dosage:** [e.g., 10mg]
- **Prescribing Physician:** [Physician Name]

I acknowledge and understand the following:

- I am responsible for ensuring a secure location for delivery.
- I understand that a signature may be required upon delivery per federal or state regulations.
- I release the pharmacy from liability once the package has been confirmed as delivered by the carrier.
- I confirm that these medications are for my personal medical use as directed by my physician.

This authorization remains in effect until [End Date] or until I provide written notice of revocation.

Sincerely,

_____
[Patient Signature]

Patient Phone Number: [Phone Number]
Patient Email: [Email Address]