

Date: [Insert Date]

To: [Pharmacy Name]

Fax/Email: [Pharmacy Contact Information]

Prescription Delivery Authorization Letter

Patient Information:

Patient Full Name: [Child's Full Name]

Date of Birth: [MM/DD/YYYY]

Insurance Member ID: [ID Number]

Parent/Guardian Information:

Parent/Guardian Name: [Your Full Name]

Relationship to Patient: [e.g., Mother, Father, Legal Guardian]

Phone Number: [Your Phone Number]

Shipping Address:

[Street Address]

[City, State, Zip Code]

To Whom It May Concern,

I, [Your Full Name], am the parent or legal guardian of the patient listed above. I hereby authorize [Pharmacy Name] to fill and deliver prescriptions for my child via mail-order service to the shipping address provided.

I confirm the following:

- I authorize the pharmacy to charge the [Credit Card/Payment Method] on file for any applicable co-pays or shipping fees.
- I understand that some medications may require a signature upon delivery.
- I acknowledge that it is my responsibility to notify the pharmacy of any changes to the patient's address, insurance, or health status.

This authorization shall remain in effect until I provide written notice of cancellation.

Authorized Signature: _____

Print Name: [Your Full Name]