

Date: [Insert Date]

To:

[Pharmacy Name]

[Pharmacy Address]

[City, State, Zip Code]

Subject: Authorization for Mail-Order Prescription Delivery

To whom it may concern,

I, [Patient Full Name], born on [Patient Date of Birth], hereby authorize [Pharmacy Name] to deliver my prescription medications via mail-order service to my designated residence.

Delivery Address:

[Recipient Name/Care Facility Name]

[Street Address]

[Apartment/Suite Number]

[City, State, Zip Code]

I confirm that I am a patient under the care of [Doctor Name]. I authorize the pharmacy to process payments using the insurance information and credit card on file. I also acknowledge that I am responsible for ensuring a safe location for the receipt of these medications.

In the event of any changes to my health status, address, or insurance, I agree to notify the pharmacy immediately.

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

Sincerely,

[Signature]

[Printed Name]

[Phone Number]

Legal Representative (if applicable):

Relationship to Patient: [e.g., Power of Attorney, Spouse, Child]

Representative Signature: _____