

Date: [Date]

To: [Mail-Order Pharmacy Name]

Address: [Pharmacy Address]

City, State, Zip: [Pharmacy City, State, Zip]

Subject: Authorization for Third-Party Caregiver Prescription Delivery

To Whom It May Concern,

I, [Patient Name], born on [Patient Date of Birth], with Member ID number [Insurance/Member ID], hereby authorize [Name of Caregiver/Third-Party] to manage and receive my prescription medications through your mail-order service.

Specifically, I authorize the person named below to:

- Communicate with the pharmacy regarding my prescriptions.
- Update shipping addresses and contact information.
- Sign for and accept delivery of my medications.
- Provide payment information for co-pays or balances.

Caregiver Information:

Name: [Caregiver Name]

Relationship to Patient: [Relationship]

Phone Number: [Caregiver Phone Number]

Address: [Caregiver Address]

This authorization is effective as of [Start Date] and will remain in effect until [End Date or "further notice"]. I understand that I can revoke this authorization at any time by notifying the pharmacy in writing.

Sincerely,

[Patient Signature]

[Printed Patient Name]

[Patient Phone Number]