Families First

support for families...health care for all

Prescription Authorization Form

I, _____

Patient's Full Name (please print clearly) D.O.B. Phone Number

_____

Address City, State

give permission to: _____

Full Name (please print clearly)

_____

Address City, State

_____

Phone Number

to pick up my prescription(s) at Families First on my behalf. This individual has agreed to bring my prescription(s) directly to me at all times.

This authorization is valid for ONE YEAR from the date below and may be revoked at any time in writing prior to then.

_____

Patient/Legal Guardian signature Date

_____

Print name of above signature