AUTHORIZED PHARMACY REPRESENTATIVE

This is to inform you that I:

_____

(PRINT First Name and Last Name as appears in your SCVMC medical records)

Authorize:

_____

(PRINT First Name and Last Name of person authorized to pick up medication)

To act on my behalf in placing pharmacy orders and picking up my medication or other medical supplies obtained through **SCVMC Pharmacy**. I understand that my representative may be asked for up to two (2) forms of identification and that it is my responsibility to make them aware of this.

Medical Record Number _____ **Signature** _____

Contact Phone Number _____ **Date** _____

AUTHORIZED PHARMACY REPRESENTATIVE

This is to inform you that I:

_____

(PRINT First Name and Last Name as appears in your SCVMC medical records)

Authorize:

_____

(PRINT First Name and Last Name of person authorized to pick up medication)

To act on my behalf in placing pharmacy orders and picking up my medication or other medical supplies obtained through **SCVMC Pharmacy**. I understand that my representative may be asked for up to two (2) forms of identification and that it is my responsibility to make them aware of this.

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