MEDICATION AUTHORIZATION FORM

Boston Mountain Rural Health Center, Inc.

I authorize the following individuals to pick up medications and/or prescriptions on my behalf from Boston Mountain Rural Health Center, Inc. I understand that without this written authorization my medications and/or prescriptions may not be released. In the event that I have sent someone who is not on this list, every effort will be made to verify authorization via phone call. If unable to verify authorization by phone, and permission is not given on this form, medications cannot be released to anyone else.

The following people have my permission to pick up medications/prescriptions from BMRHC on my behalf:

_____

_____

_____

IF YOU CHOOSE TO DISCONTINUE AUTHORIZATION FOR THE ABOVE NAMED INDIVIDUALS, IT IS YOUR RESPONSIBILITY TO NOTIFY BMRHC.

I have read and agree to the above conditions.

_____ Date: _____

Patient's Signature

_____ Date: _____

Witness