

## PERMISSION TO PICK UP PRESCRIPTIONS

Note: This form authorizes permission to pick up prescriptions from any persons other than parent/legal guardian whose name is signed below

Name of Child:	Date of Birth:	
(Parent/Guardian) medication (including a controlled substar	give the following individual(s) my permission to pick up any prescr nce) provided to the child. I understand that such authorization does t provided outside the offices of Anderson Hills Pediatrics, Inc.	
Name	Relationship to Minor Child	
Check one of the following boxes:		
This notice is effective only on th	e following date(s):	
This notice is effective from the c	late below until revoked.	
I understand that this notice will not expire	anless revoked by me in writing.	
Parent/Guardian – Print Name		
Parent/Guardian - Signature	Date	
VERBAL CONSENT OBTAINED FRO	OM PARENT/GUARDIAN	
Name of Parent/Guardian: Date: Verbal consent effective only on the follow Name of individual documenting consent: Form sent to parent/guardian to follow-up		