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Jefferey D. Adair, MD
Fellowship-trained in Pain Management
Double Board Certified in
Anesthesiology & Pain Management

PRESCRIPTION PICK UP AUTHORIZATION

Patient Name: _____

Date of Birth: _____

I hereby authorize the following person(s) to pick-up or exchange any prescriptions at the request of Dr. Adair on my behalf. I understand that any person(s) not listed will be denied access to pick up my prescriptions.

- Person(s) authorized must be 18 years or older
- Person(s) picking up prescription(s) must provide their driver's license or photo identification at time of pick-up.

All prescriptions must be signed for by the recipient. Failure to comply with any of the above will result in the inability to pick up prescriptions.

1. _____

Relation to Patient _____ DOB _____

2. _____

Relation to Patient _____ DOB _____

3. _____

Relation to Patient _____ DOB _____

Patient may update this form at any time. We cannot receive verbal permission for prescription pick-up. Any changes must be submitted on this form.

Please sign below, attesting that you have read and understand these policies.

_____

Patient Signature Date