Florida Medical Supply Pharmacy

5314-A Frank Hough Road
Panama City, Florida 32404
1-850-785-1900

PRESCRIPTION PICK-UP/DELIVERY AUTHORIZATION

Please note that _____ is/are authorized to receive and process all my prescription medications and deliver them to me. I understand that this agent(s) MUST sign each delivery receipt from the pharmacy as proof of delivery/acceptance of the special packaged medications.

_____
(Patient's printed name)

_____
(Patient's signature)

_____ _____/_____/_____
(Patient's Social Security Number) (Date Signed)