Planned Parenthood
COLUMBIA WILLAMETTE

Request and Consent for Prescription Pick-up

Please print your full name: _____

Please record Your birth date: _____/_____/_____

Health Center MRN: _____

Please complete this form if you choose to have someone else pick up a prescription on your behalf at one of our health centers. Please verify that your prescription is still valid prior to pick-up by calling 1-888-875-7820.

I hereby request and consent to Planned Parenthood Columbia Willamette (PPCW) releasing my prescription

for: ☐ birth control ☐ antibiotic/antiviral/antifungal ☐ other_____

to: (name of person picking up)_____.

Pick-up location:

☐ Beaverton Health Center:	12220 SW 1st St. Suite 200, Beaverton, OR 97005
☐ Bend Health Center:	2330 NE Division St. Suite 7, Bend, OR 97701
☐ Clackamas Health Center:	16068 SE 82nd Dr., Clackamas, OR 97015
☐ Gresham Health Center:	501 NE Hood Ave. Suite 100, Gresham, OR 97030
☐ McMinnville Health Center:	130 NW 6th St. Suite A, McMinnville, OR 97128
☐ Mt. Hood Community College:	26000 SE Stark St., Gresham, OR 97030
☐ Northeast Portland Health Center:	3727 NE MLK Jr. Blvd., Portland, OR 97212
☐ Salem Health Center:	3825 Wolverine St. NE, Salem, OR 97305
☐ Salmon Creek Health Center:	2105 NE 129th St. Suite 105, Vancouver, WA 98686
☐ Southeast Portland Health Center:	3231 SE 50th Ave., Portland, OR 97206
☐ Vancouver Health Center:	5500 NE 109th Ct. Suite A, Vancouver, WA 98662

I have informed the person above that they must **show photo ID at every pick-up** to receive my prescription.

I understand that once the prescription is released to the person named above, PPCW is not responsible for the delivery or loss of the prescription or for any subsequent action taken in regards to the prescription.

_____ Date: _____/_____/_____

Client Signature

This form is valid for one year from date signed.

Optional Renewal of Request & Consent:

_____ Date: _____/_____/_____

Client Signature

This form is renewed for one year from date signed

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To be completed by Health Center Staff:

☐ I certify that the client's **signature and birth date above match** the client's medical record.

☐ I have entered a Quicknote in NextGen with the name of the authorized person & expiration date of this consent.

☐ I have placed this form in the client's medical record on top of the Refill Record.

_____ Date: _____/_____/_____

PPCW Staff Signature

Record pick-up date and initials of person verifying photo ID at each pick-up:

Photo ID verified		***Photo ID verified***		***Photo ID verified***		***Photo ID verified***		***Photo ID verified***	
Date	*By*	*Date*	*By*	*Date*	*By*	*Date*	*By*	*Date*	*By*