

**PERMISSION FOR MEDICATION PICK-UP**

In order to protect the privacy of our patients, Planned Parenthood Arizona will only release medications to friends, relatives, or partners with your direct consent. If you plan to have someone pick up your medication, please fill out the information below for our records.

Patient Name \_\_\_\_\_  
(please print)

Date of Birth \_\_\_\_\_ CVR# \_\_\_\_\_

I give my permission for \_\_\_\_\_

**To:** Pick up contraception for me;  
YES \_\_\_\_\_ NO \_\_\_\_\_

And / or other medications.  
YES \_\_\_\_\_ NO \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

If there is a time limit or specific date, please note that also.  
In this way, we will be able to better serve your needs.

Time limit or specific date \_\_\_\_\_

Please note: This permission slip only authorizes the release of medications to another individual. If you wish for medical information to be released, please request an "AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION".