AUTHORIZATION to REPRESENT

I, _____, directly or indirectly through the signature of my legal guardian or
(Print Name)
representative, hereby appoint, _____, to be my Authorized Representative for
(Print Name)
obtaining medications from My Neighbor's Charitable Pharmacy.

My Authorized Representative may:

- Pick up my medications and consent to any required pharmacist consultation.
- Execute Patient Assistance Program (PAP) applications on my behalf from the companies that make such medicines if I am participating in a PAP for such medications.
- Obtain information regarding my medication records, federal/state programs application status, employment status, income, and assets to substantiate my application(s).

The rights, powers, and authority of my Authorized Representative will remain in full force and effect until the conclusion of my application(s), when revoked in writing by me or my legal representative, or when terminated by my Authorized Representative. I understand that I must revoke this Authorization to Represent in writing and that revocation of my Authorized Representative is not effective until My Neighbor's Charitable Pharmacy is notified of the revocation in writing.

The undersigned certifies that I have reviewed the above provisions, had an opportunity to ask questions, and that all of my questions have been answered to my satisfaction. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute this Authorization to Represent and accept the terms hereof.

Signature of Patient (or Legal Guardian/Representative)	Date of Birth	Date

Printed Name	Relationship