My Neighbor's Charitable Pharmacy
Medication Access Program

AUTHORIZATION to REPRESENT

I, ________________________, directly or indirectly through the signature of my legal guardian or
(Print Name)
representative, hereby appoint the My Neighbor's Charitable Pharmacy Medication Access Program, its employees and agents, to be my Authorized Representative for obtaining medications.

My Authorized Representative may:

- 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 Neighbor's Pharmacy as my Authorized Representative is not effective until Neighbor's Pharmacy, or any third party, is notified of the revocation in writing.

I attest that the information I have given in this enrollment application is accurate and true. I also understand that even if my application is approved, provision of medicines is not guaranteed. All applications are reviewed on a case-by-case basis. A copy of this Authorization to Represent shall have the same force as the original.

Check only one:

☐ **I authorize Neighbor's Pharmacy Medication Access program representatives to sign prescription assistance applications on my behalf.**

☐ I *do not* authorize Neighbor's Pharmacy Medication Access program representatives to sign prescription assistance applications on my behalf. Instead, I will complete all documents on my own and submit them on my own. I understand this may delay receiving my medications, and I will be required to call the drug company's PAP to refill my medications. However, refusal to allow Neighbor's Pharmacy Medication Access program representatives to sign forms on my behalf has no impact with respect to my ability to use the other Neighbor's Pharmacy services.

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	