



4505 Maryland Parkway Box 453020 Las Vegas, Nevada 89154-3020
(702) 895-0278 FAX (702) 895-0698

AUTHORIZATION FOR RELEASE OF PATIENT PRESCRIBED MEDICATION

This authorization allows the University of Nevada, Las Vegas Student Health Center Pharmacy to release medication(s) to the person authorized by me.

(PLEASE PRINT)

Patient Last Name	First Name	M.I.
Date of Birth	Social Security No.	

I hereby authorize: UNLV Student Health Center Pharmacy
4505 Maryland Parkway Box 453020
Las Vegas, NV 89154-3020
Phone No. (702) 895-3370

To release the following prescribed medication(s)

Name of Medication	Patient Initials

To:

Name of person picking up medication(s)	Relationship to patient
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I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken. This authorization will remain valid for the entire current school year, unless otherwise indicated by the patient.

The University, Student Health Center and Student Counseling and Psychological Services, its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for releasing of your medication(s) to the extent indicated and authorized.

Contact number where we may reach you: _____

Signature of Patient: _____ Date: _____