# RELEASE OF CONTROLLED SUBSTANCE PRESCRIPTIONS

I, _____ (please print name)
give permission for:

_____ (please print name)
_____ (address)
_____
_____ (contact phone #)
_____ (DL #)

to pick up controlled substance prescription(s) for me/my child.

I absolve Psychiatric Associates of Austin, PA of any responsibility if the controlled substance prescription(s) that are released to the above named individual are lost or stolen. I understand there will be a $25.00 lost prescription charge and I will not be able to get a replacement prescription.

_____ (Sign) _____ (Date)

I am aware that I will have to present my driver's license to pick up the requested prescription. If the prescription that is released to me is lost or stolen my information listed above will be reported to the Department of Public Safety.

_____ (Sign) _____ (Date)