Client Representative Authorization Form

Client Name:_____ Date of Birth:_____ Client ID:_____

Address:_____ Phone:_____

I give the designated representative the legal authority to sign Form OHP 3166 on my behalf. This authority will remain in effect until:

_____ 11:59pm on _____/_____/_____.

_____ revoked in writing.

Designated Representative's name (please print): _____

Designated Representatives signature:_____

Client Signature: _____ Date:_____/_____/_____

STAYTON PHARMACY LLC
102 MARTIN DR. STE A
STAYTON, OR 97383 (503) 769-2616