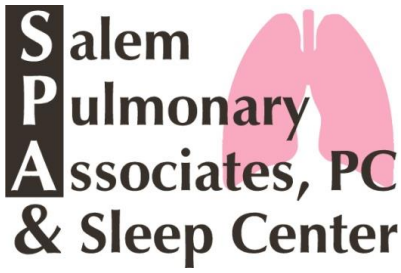

STEVEN MARVEL MD
MARTIN C JOHNSON MD
KAMRAN FIROOZI MD
FAYEZ BADER MD
NIMESHKUMAR MEHTA MD
WENNJEAN NG MD
KAVAN RAMACHANDRAN MD
KISHAN RAMACHANDRAN MD
BIJAYA SHRESTHA MD
KOVID TRIVEDI MD

PRESCRIPTION PICK-UP AUTHORIZATION

Patient Name:_____ DOB:_____
(Please Print)

I, _____, hereby authorize the individual(s) listed below to pick up my prescription(s) for me at Salem Pulmonary Associates, PC & Sleep Center.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that my delegate/representative must provide photo identification and sign our prescription pick-up log each time he/she picks up my prescription(s). This authorization will remain active until I revoke it by contacting the staff at Salem Pulmonary Associates, PC & Sleep Center.

_____ _____
Patient signature Date