Consent to Receipt of Medications in Non-Child Resistant Containers

I hereby request that all medications* provided to me shall be delivered and received in a non-child-resistant container. I am not able to use child resistant containers because:

Patient Name (Print):

Signature:

Dated:

Optional:

(If a Power of Attorney has been provided, then please fill out the following information)

Power of Attorney Name (Print):

Signature:

* Note: only for bottled medication (not blister packaged medication)

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