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I authorize AWH to discuss my Protected Health Information with the following person/s:

Date of Birth:	Date of Birth:
Relationship:	Relationship:
Name:	Name:
Date of Birth:	Date of Birth:
Relationship:	Relationship:
Signature:	Date:
I would like to REMOVE the following p	person/s from having access to my Protected Health
Information:	
Name:	Name:
Date of Birth:	Date of Birth:
Signature:	Date: