

**FAMILY PLANNING HEALTH SERVICES, INC
PILL PICK UP PERMISSION SLIP**

I _____, DATE OF BIRTH _____,

Give the following people listed, permission to pick up my pills
I will notify the clinic should I want a name added or deleted from this list.

SIGNATURE _____ **DATE** _____

	NAME	RELATIONSHIP
1.	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

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