OSPHL Web Access to Test Results

FACILITY MASTER AUTHORIZATION FORM

Authorized Access Grantor (AAG) Information

Facility Name_____
Department _____
Phone _____ Fax _____
Street Address: _____
City _____ State _____ Zip _____

Individual named as this facility's AAG:
Dr./Mr./Ms._____
Title _____
E-mail_____
Signature_____

Alternate AAG (if applicable)
Individual named as this facility's AAG:
Dr./Mr./Ms._____
Title _____
E-mail_____
Signature_____

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