



**THE HAND CENTER
OF WESTERN MASSACHUSETTS**

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**THE HAND CENTER OF WESTERN MASSACHUSETTS
PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ Patient DOB: _____
*If patient is a minor, a parent or guardian must sign.

Patient Signature: _____ Chart #: _____
*Patient, parent or guardian

Date: _____