THE HAND CENTER
OF WESTERN MASSACHUSETTS

3550 Main Street, Suite 204
Springfield, MA 01107
(413) 733-2204
Fax (413) 734-0587

Revocation Form

I hereby revoke my prior authorization for The Hand Center of Western Massachusetts to release information to

_____.

Patient Name: _____

Relationship:_____

*Patient, parent or guardian

Patient Signature: _____ Date: _____

*If patient is a minor, a parent or guardian must sign.