T H E H A N D C E N T E R
OF WESTERN MASSACHUSETTS
3550 Main Street, Suite 204
Springfield, MA 01107
(413) 733-2204
Fax (413) 734-0587

Medical Record Release From

I hereby authorize The Hand Center of Western Massachusetts to release any and all information regarding my medical treatment to

____

( ) Forward To This Address:

____

____

____

( ) Fax To This Number:

____

Signature: ____

*Patient, parent or guardian

Date: ____

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