THE HAND CENTER
OF WESTERN MASSACHUSETTS
3550 Main Street, Suite 204
Springfield, MA 01107
(413) 733-2204
Fax (413) 734-0587

Medical Record Release To

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

Mailing Address is: 3550 Main Street, Suite 204
Springfield, MA 01107

Telephone: (413) 733-2204

Fax: (413)734-0587

Signature: ____
*Patient, parent or guardian

Date: ____

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