

			Manet Community Health Center
			9 Bicknell Street
			Quincy MA 02169
The constitution of the state o			Secured Fax Lines: 317-454-8573
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	Authorization to	o Release and/or Obtain Protected Health Inforr	nation
Patient Name:		Date of Birth:	
Address:	City:	State:	Zip;
Email:	Phone: (H):	(W)	(C)
I hereby authorization M	lanet Community Health Center	; Inc. to (please check one box only) D Send m	y health information to
Name (of facility):			
Address:	Cit	ly:Stat	e: Zip:
	Vii	yotal	Ζιρ.
Phone:	Fax#:	Email:	tenner en
ormat of information to be	e released: (please check box) 🔲 Pa	aper	the fine of the factors and the major control the first comparison and the major to the first control of the first
☐ I wish to pick up my re	cords: (medical records will contact yo	ou when ready for pick-up)	
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