

FaxCover

To: _____

RECIPIENT FAX: _____

RECIPIENT PHONE: _____

FROM: _____

DATE: _____

PAGES: _____

INCLUDING COVER

RE: _____

This transmission is intended only for the addressee named to the left. It may contain information that is privileged, confidential and exempt from disclosure under applicable law from sue and disclosure. If you are not the intended recipient, you are hereby notified that any review, disclosure, copying or dissemination of the transmission is strictly prohibited. **If you have received this transmission in error, please notify us immediately by telephone at the number below so that we can arrange for its return to us.** Thank you for your cooperation.

Hopkinton Family Practice

77 West Main Street, Suite 204 • Hopkinton, MA 01748

508-435-4414 • FAX 508-435-4434

A member of the Milford Regional Healthcare System