Springfield MEDICAL CENTER, P.C.
Back & Neck Pain . Primary Care . Physical Medicine

Dr. Albert L. Valente
Board Certified Internal Medicine

Dr. Suzanne Lagosky
Certified Physical Medicine & Rehabilitation

Patient Authorization for Use and Disclosure of Protected Health Information (HIPPA)

It is the policy of our practice that all Practitioners and staff preserve the integrity and the confidentiality of 'protected health information' (PIH) pertaining to our patients. Please list anyone that you would like to have access to your Medical Records and their relationship to you. You have the right to revoke this authorization in writing, except to the extent that the practice has acted in reliance upon this authorization. Your authorization must be submitted to the privacy office at Springfield Medical Center, P.C.

By signing this authorization I authorize Springfield Medical Center, P.C. to use and/or disclose certain protected health information about me to the following persons.

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I have been given the opportunity to read The Notice of Privacy Practices as required by HIPPA guidelines at Springfield Medical Center, P.C.

_____	_____	_____
Print your full name	Signature of Patient	Date

3970 Springfield Road, Glen Allen, Virginia 23060
(804) 747-8400 • Fax: (804) 747-8170