Patient Care Collaboration Agreement

Date: [Insert Date]

To: [Collaborating Provider's Name]
[Collaborating Provider's Title]
[Collaborating Provider's Organization]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

Dear [Collaborating Provider's Name],

We are writing to formalize our collaboration in providing comprehensive care for our mutual patient, [Patient's Name], who is under treatment for [brief description of the medical condition]. This agreement outlines our shared responsibilities and expectations as we work towards the optimal health outcomes for [Patient's Name].

1. Purpose

The purpose of this agreement is to ensure coordinated care that adheres to best practices and meets the needs of [Patient's Name].

2. Roles and Responsibilities

Each party agrees to the following responsibilities:

- Provider 1: [Insert responsibilities]
- Provider 2: [Insert responsibilities]

3. Communication

Regular communication will be maintained to discuss patient progress and any changes in treatment plans, which will include:

- Scheduled meetings every [insert frequency]
- Exchange of patient information as needed

4. Confidentiality

All patient information will be kept confidential and shared only as necessary for the collaborative care of [Patient's Name], in compliance with HIPAA regulations.

5. Agreement Duration

This agreement shall remain in effect until [Insert End Date], unless amended or terminated by mutual consent.

Thank you for your collaboration in providing the best care for our patient. Please sign and return a copy of this agreement to confirm our partnership.

Sincerely,

[Your Name]
[Your Title]
[Your Organization]
[Your Contact Information]

Signed: _____
[Collaborating Provider's Name]
[Date]