Patient Confidentiality Assurance

Date: [Insert Date]

[Recipient's Name]

[Recipient's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

This letter is to confirm our commitment to maintaining the confidentiality of patient information as required by applicable laws and regulations.

We understand that you may require access to certain patient information for [specific reason, e.g., coordination of care, billing purposes, etc.]. Please be assured that all patient information shared will be handled with the utmost confidentiality and will only be disclosed in accordance with HIPAA regulations and the patient's consent.

Should you have any questions or require further information concerning our confidentiality practices, please do not hesitate to reach out at [Your Contact Information].

Thank you for your cooperation in upholding the privacy of our patients.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]