

Patient Confidentiality Notice

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Dear [Patient's Name],

We are committed to ensuring the confidentiality and security of your health information while you receive telehealth services. This notice serves to inform you of your rights regarding your health information and the measures we take to protect it.

Confidentiality of Your Health Information

All telehealth consultations will be conducted in a private, secure environment. We utilize encrypted communication tools to safeguard your personal health information (PHI).

Your Rights

You have the right to:

- Access your health information.
- Request amendments to your health records.
- Request restrictions on the disclosure of your health information.

Contact Information

If you have any questions or concerns regarding this notice or your health information, please contact us at:

Email: [Insert Email]

Phone: [Insert Phone Number]

Thank you for choosing [Healthcare Provider's Name] for your telehealth services.

Sincerely,

[Your Name]

[Your Title]

[Healthcare Provider's Name]