Patient Confidentiality Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Address: [Insert Patient Address]

Dear [Patient Name],

This agreement outlines the confidentiality terms concerning your medical information. We are committed to ensuring that your personal health information is safeguarded and used only for purposes that directly relate to your care.

Confidentiality Terms

- Your medical records will only be accessible to authorized personnel.
- Any information sharing will require your written consent, except in cases of medical emergency.
- We will adhere to all HIPAA regulations to protect your health information.

By signing this document, you acknowledge that you understand and agree to the terms outlined above.

Patient Signature: _____

Date: _____

Thank you for trusting us with your health care needs.

Sincerely,

[Your Organization Name]

[Contact Information]