Patient Privacy Agreement

Date: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____

Dear [Patient's Name],

At [Clinic Name], your privacy is our priority. This Patient Privacy Agreement outlines how we will protect your personal information and maintain confidentiality during your care.

Information We Collect

We may collect information including but not limited to:

- Personal identification details
- Medical history
- Financial information

How We Use Your Information

We use your information to:

- Provide you with quality medical care
- Process payments
- Communicate important updates regarding your treatment

Confidentiality

Your information will be kept confidential and will not be shared without your consent, except as required by law.

Patient Rights

You have the right to access your medical records, request corrections, and receive information on how your data is used and shared.

Agreement

By signing below, you agree to the terms outlined above regarding the use and confidentiality of your personal information.

Patient Signature: _____

Date: _____

If you have any questions or concerns regarding this agreement, please do not hesitate to contact us at [Clinic Phone Number] or [Clinic Email].

Sincerely,
[Clinic Name]
[Clinic Address]