Patient Privacy Agreement

Date: _____

Patient Name: _____

Patient Address: _____

Dear [Patient's Name],

We are committed to protecting your privacy and maintaining the confidentiality of your medical information. This agreement outlines how we will handle your personal health information.

Information We Collect

We may collect personal information including but not limited to:

- Contact Information
- Medical History
- Treatment Plans
- Insurance Information

Use of Your Information

Your information will be used for:

- Treatment purposes
- Billing and payment
- Communication about your care

Disclosure of Information

We will not disclose your personal information without your consent, except as required by law or to fulfill your treatment needs.

Patient Rights

You have the right to:

- Access your health records
- Request corrections to your information
- Receive an accounting of disclosures

Acknowledgment

By signing below, you acknowledge that you have read and understand the terms of this Patient Privacy Agreement.

Patient Signature: _____ Date: _____

Thank you for trusting [Dental Practice Name] with your dental care.

Sincerely,

[Your Name]
[Your Title]
[Dental Practice Name]
[Contact Information]