Patient Privacy Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Address: [Insert Patient Address]

Healthcare Provider: [Insert Healthcare Provider Name]

Address: [Insert Provider Address]

Introduction

This Patient Privacy Agreement outlines how your medical information will be used and protected in accordance with applicable laws and regulations.

Purpose of Information

Your personal health information may be used for treatment, payment, and healthcare operations.

Patient Rights

- The right to inspect and obtain a copy of your health information.
- The right to request amendments to your records.
- The right to request restrictions on uses and disclosures.

Confidentiality Assurance

We are committed to protecting your privacy and will not disclose your information without your consent, unless required by law.

Agreement Acknowledgment

By signing below, you acknowledge that you have read and understood this Patient Privacy Agreement.

_____
Patient Signature

Date: _____

Contact Information

If you have any questions about this agreement, please contact:

[Insert Contact Information]

Thank you for trusting us with your healthcare needs.