

Patient Privacy Agreement

Date: _____

Patient Name: _____

Facility Name: _____

Address: _____

Dear [Patient's Name],

Thank you for choosing [Facility Name] for your long-term care needs. We are committed to protecting your privacy and ensuring that your personal and health information remains confidential.

Privacy Practices

At [Facility Name], we adhere to the following principles:

- Your health information will be used only for the purpose of providing you care.
- We will not disclose your information without your consent, except as required by law.
- You have the right to access your health information.

Signature

By signing below, you acknowledge that you have received and understand our Patient Privacy Agreement.

Patient Signature

Date

If you have any questions regarding this agreement, please do not hesitate to contact us at [Facility Contact Information].

Sincerely,

[Facility Administrator's Name]
[Facility Name]