# Patient Privacy Agreement

Date: ___________

Patient Name: ___________

Address: ___________

City, State, Zip: ___________

Phone Number: ___________

Email: ___________

## Introduction

This Patient Privacy Agreement outlines the practices of our mental health services related to the collection, use, and disclosure of your personal information.

## Confidentiality

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

## Data Collection

We collect personal information to provide you with appropriate care. This may include your medical history, treatment plans, and any relevant personal details.

## Your Rights

You have the right to access your records, request amendments, and know how your information is being used.

## Consent

Your signature below indicates that you understand and agree to the terms outlined in this Patient Privacy Agreement.

## Signature

____________________________

Patient Signature

# Date

______________________________

Date