Patient Privacy Agreement

Date: [Insert Date]

[Pharmacy Name]

[Pharmacy Address]

[City, State, Zip Code]

Dear [Patient's Name],

We are committed to protecting your personal information and maintaining your privacy. This letter serves as a formal agreement regarding our pharmacy services and the handling of your private health information.

Privacy Practices

At [Pharmacy Name], we adhere to the Health Insurance Portability and Accountability Act (HIPAA) regulations. We assure you that your health records and any personal information will be kept confidential and secured.

Information We Collect

We collect various types of information about you including, but not limited to:

- Your name, address, and date of birth
- Medical history and prescription records
- Insurance information

Use of Information

Your information may be used for the following purposes:

- Provision of pharmacy services
- Billing and insurance verification
- Communication regarding your health

Your Rights

You have the right to:

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

Please read this agreement carefully. By signing below, you acknowledge that you understand and agree to the terms outlined in this Patient Privacy Agreement.

Thank you for choosing [Pharmacy Name]. If you have any questions or concerns, please do not hesitate to contact us at [Pharmacy Phone Number].

Sincerely,

[Pharmacist's Name]

[Title]

[Pharmacy Name]

Patient Signature: _____ Date: _____