Patient Privacy Agreement for Telehealth Services

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Dear [Insert Patient Name],

We are committed to protecting the privacy and security of your health information. This Patient Privacy Agreement outlines how we will manage and protect your personal health information during telehealth services.

Information We Collect

We may collect the following information during your telehealth appointments:

- Personal identification information
- Medical history
- Health status updates

Use of Information

Your information will only be used for the following purposes:

- To provide healthcare services
- To communicate with you about your care
- For billing and payment processes

Confidentiality

We ensure that your healthcare information is kept confidential and secure, in compliance with HIPAA regulations.

Your Rights

You have the right to:

- Request access to your health records
- Request amendments to your health information

- Receive a list of disclosures made regarding your information

Consent

By signing this agreement, you consent to the use and disclosure of your health information as described above.

Thank you for choosing us for your telehealth services. Please acknowledge your understanding of this agreement by signing below.

Signature: ___________________________

Date: ________________________________

If you have any questions regarding this agreement, please feel free to contact us.

Sincerely,

[Healthcare Provider's Name]

[Healthcare Provider's Contact Information]