Patient Consent Form

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Subject: Consent for Treatment and Privacy Practices

Dear [Patient's Name],

We are committed to protecting your privacy and ensuring compliance with the Healthcare Privacy Regulations. This letter serves as confirmation that you have received and understood our privacy practices regarding your personal health information (PHI).

By signing this consent form, you agree to the following:

- We may use and disclose your PHI for treatment, payment, and healthcare operations.
- You have the right to access your medical records and request amendments.
- You have the right to restrict certain uses and disclosures of your PHI.
- You will be informed of any changes to our privacy practices.

If you have any questions or concerns about this consent or our privacy practices, please do not hesitate to contact our office.

By signing below, you confirm that you understand and consent to the use of your personal health information as described above.

_____

Patient Signature

Date: _____

Thank you for trusting us with your healthcare needs.

Sincerely,

[Your Healthcare Provider's Name]

[Your Healthcare Facility's Name]

[Contact Information]