Patient Confidentiality Agreement

Date: _____

To Whom It May Concern,

This agreement is made between **[Hospital Name]** and **[Patient's Name]** regarding the protection of personal health information.

1. Purpose

The purpose of this agreement is to ensure that the personal health information of the patient is kept confidential and protected in accordance with applicable laws and regulations.

2. Confidentiality Obligations

The hospital agrees to safeguard the patient's information from unauthorized disclosure and to limit access to the patient's health information to only those who need to know for treatment, payment, or healthcare operations.

3. Patient Rights

The patient has the right to request restrictions on certain uses and disclosures of their health information, as well as the right to access and amend their records.

4. Term and Termination

This agreement will remain in effect until the patient revokes it in writing or the patient is no longer receiving services from the hospital.

5. Acknowledgment

By signing below, both parties acknowledge and agree to the terms of this confidentiality agreement.

_____
Patient's Signature
Date: _____

_____
Authorized Representative, [Hospital Name]
Date: _____