Patient Confidentiality Agreement

Date: [Insert Date]

To: [Patient's Name]

From: [Practitioner's Name]

Practice Name: [Practice Name]

Address: [Practice Address]

Phone: [Practice Phone Number]

Dear [Patient's Name],

This letter serves to confirm our agreement regarding the confidentiality of your personal health information. As your practitioner, I am committed to protecting your privacy and ensuring that your medical information remains confidential in accordance with federal and state regulations.

1. I will not disclose any of your health information to third parties without your explicit consent, except when required by law.

2. You have the right to access your medical records and request corrections if necessary.

3. I will implement appropriate security measures to protect your health information from unauthorized access or disclosure.

Please sign below to acknowledge your understanding and acceptance of this confidentiality agreement.

_____

Patient's Signature

Date: _____

Thank you for entrusting me with your healthcare needs.

Sincerely,

[Practitioner's Name]

[Practitioner's Title]