Patient Confidentiality Agreement

Date: _____

Patient Name: _____

Address: _____

Phone Number: _____

Agreement

As a patient receiving pharmacy services, I understand the importance of my personal health information being kept confidential. This agreement outlines the commitment of [Pharmacy Name] to maintain the privacy and security of my medical records, prescription information, and any other personal information I share.

Terms

1. [Pharmacy Name] agrees to protect my personal health information in accordance with HIPAA regulations.
2. Information will only be shared with authorized personnel involved in my care or as required by law.
3. I have the right to access my health records and request corrections as necessary.
4. This agreement will remain in effect until revoked by me in writing.

Patient Acknowledgment

I, the undersigned, acknowledge that I have read and understood the terms of this Patient Confidentiality Agreement and agree to abide by its provisions.

Patient Signature: _____

Date: _____

Pharmacy Representative Signature: _____

Date: _____