Patient Confidentiality Agreement

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Address: [Insert Patient Address]

Phone Number: [Insert Patient Phone Number]

Agreement

This Patient Confidentiality Agreement is made between [Clinic Name], hereinafter referred to as "the Clinic," and the patient named above, hereinafter referred to as "the Patient."

The Clinic is committed to protecting the confidentiality of the Patient's personal and medical information in compliance with applicable laws and regulations.

Terms of Confidentiality

1. The Clinic agrees to keep all patient information confidential and only disclose it with the Patient's consent or as required by law.
2. The Patient has the right to access their medical records and request amendments if necessary.
3. The Patient's information will not be shared with third parties without explicit consent, except where required by law.

Duration of Agreement

This agreement will remain in effect as long as the Patient is receiving treatment at the Clinic, and even after treatment has concluded, in regard to records maintained by the Clinic.

Signature

By signing below, the Patient acknowledges that they have read and understood this confidentiality agreement and agree to its terms.

Patient Signature: _____

Date: _____

Clinic Representative Signature: _____

Date: _____