Patient Confidentiality Agreement for Telehealth Services

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Address: [Insert Patient Address]

Email: [Insert Patient Email]

Dear [Patient Name],

This letter serves as a confidentiality agreement between [Your Telehealth Practice Name] and you, the patient, regarding the use of telehealth services. We are committed to protecting your privacy and ensuring the confidentiality of your health information.

Confidentiality Commitment

All personal health information (PHI) will be kept confidential and will not be disclosed to any third parties without your explicit consent, except as required by law.

Telehealth Services

By participating in telehealth services, you understand and acknowledge that:

- Telehealth communications may not be as secure as in-person visits.
- We will take reasonable measures to protect your information during telehealth sessions.
- You have the right to request alternatives to telehealth services.

Consent

By signing below, you consent to the use of telehealth services and acknowledge that you understand your rights regarding patient confidentiality.

_____

Patient Signature: [Insert Signature Line]

_____

Provider Signature: [Insert Provider Name]

Thank you for choosing [Your Telehealth Practice Name]. We look forward to providing you with high-quality telehealth services.

Sincerely,

[Your Telehealth Practice Name]

[Your Contact Information]