Patient Confidentiality Agreement

Rehabilitation Center

This agreement is made between the patient and the Rehabilitation Center to ensure the privacy and confidentiality of patient information as required by law and ethical standards.

- I understand that all information regarding my treatment, diagnosis, and personal details will be treated as confidential.
- I authorize the Rehabilitation Center to use or disclose my information only for purposes related to my treatment, payment, or healthcare operations, unless otherwise permitted or required by law.
- I understand that my written consent is required for any release of my information outside the conditions described above.
- I acknowledge that I have been informed of my rights regarding confidentiality and the circumstances under which information may be released without my consent.
- I am aware that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

I have read and understand this Confidentiality Agreement. I agree to abide by its terms and acknowledge receipt of a copy of this agreement.

Patient Name:

_____

Signature:

_____

Date:

_____

Staff Witness Name:

_____

Staff Signature:

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