Sexual Health Clinic

Patient Confidentiality Agreement Form

Patient Name

Date of Birth

I acknowledge that all information shared with the Sexual Health Clinic remains confidential and will not be disclosed to any third party without my written consent, except as required by law. I understand the importance of privacy in all matters pertaining to my health and agree to respect the confidentiality policies of the clinic.

I confirm that I have read, understood, and agree to the confidentiality agreement stated above.

Patient Signature

Date