**CONFIDENTIALITY AGREEMENT**

**GROUP MEDICAL VISIT**

The privacy of your health information is important to _____ and is mandated by law. As a participant in a Group Medical Visits, both you and the other patients will discuss medical information in the presence of other patients, staff, and the group leaders. If you have medical concerns that are of a very private nature, you may ask to discuss them with the doctor in a treatment room or schedule an individual office visit.

By signing this form you are agreeing to and authorizing the discussion of your personal medical information in the group setting each week. Your signature also means that you will respect the confidentiality of the other members of the group by not revealing medical or any other identifying information after the session is over. Your signature also means that you will not hold _____ nor any of the officers or employees of either responsible for any breach of confidentiality committed by other patients in the group.

I UNDERSTAND AND AGREE WITH THIS STATEMENT OF CONFIDENTIALITY.

_____ _____

Printed Name and Signature: Date

Name: _____

Date of birth: _____

Home address: _____

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