



## **Group Visit Confidentiality Agreement**

### **Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191) [HIPAA] Disclosures, Waiver and Confidentiality for Group Visits.**

The Health Insurance Portability and Accountability Act, regulates the sharing of private patient information. During the process of any group visit, it may be necessary to share information which would otherwise be considered private and confidential. By signing below, you consent and acknowledge:

1. That you may be asked to share information about your medical condition in the group setting, much as you would share with your medical provider in a one-to-one office visit.
2. That if you do share information about your medical condition, it may be included in the medical record (as normally occurs in any office visit)
3. That any information which is disclosed during the group visit remains confidential and subject to protection by the HIPAA regulations, when *outside* of the group. This means that any information that is shared with the group may not be discussed outside of the group, at any time.

I \_\_\_\_\_ have read and understand the above disclosure and waiver. My signature below indicates my consent to participate in this group medical visit. I understand that information that I choose to share may be part of my medical record, which remains confidential. I understand that any medical or personal information shared by others should be considered confidential and is not to be discussed outside if the group setting.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_