EXAM ROOM CONSENT

We are concerned with protecting your privacy in accordance with HIPAA regulations. We request that ONLY the patient being treated be allowed in the treatment area (with the exception of a minor), unless written consent from the patient is given.

PATIENT NAME: _____

ADDRESS: _____ **APT/UNIT:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I give my consent for _____ to accompany me into the exam room or the conference room. I understand that my personal medical information will be discussed during my treatment and I will not hold Acute Surgical Care, LLC, responsible for breach of doctor/patient confidentiality.

_____ _____

PATIENT SIGNATURE **DATE**