John B. Roach, Jr. D.O.

14100 Fivay Road Suite 130

Hudson, FL. 34667

(727)378-5808

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND PATIENT CONSENT FORM

I understand that under the Health Insurance Portability Accountability Act of 1996 ("HIPAA") that I have certain rights regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly/indirectly.

*Obtain payment form third party payers

*Conduct normal healthcare operations such as quality assessments and Physician certifications

I have received, read and understand The Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this Organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy if requested.

I understand that I may request in writing that you restrict how my information is used. I also understand that you are not required to agree to my request, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: X_____

Date: _____-