Allergy, Asthma Immunology Care

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ACKNOWLEDGEMENT

I, _____ (patient OR parent/guardian), acknowledge that I have received a copy of Allergy, Asthma, Arthritis Center of Central Florida's Notice Regarding Privacy of Personal Health Information.

_____ _____
Print Name D.O.B.

_____ _____
(Patient's Or Parent/Guardian's Signature) Date

_____ _____
Name in Print of Witness Witness Signature

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