



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

Rev. 08/2014

Triple Board Recertified Physician
Recertified Diplomate of the American Board of Allergy and Immunology
A Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics
Recertified Diplomate of the American Board of Pediatrics
Recertified Diplomate Pediatric Rheumatology – Subboard American Board of Pediatrics
Diplomate and Senior Disability Analyst of the American Board of Disability Analysts
General Acupuncture

Truly dedicated to treating patients and serving as a resource for physicians throughout the state and beyond since 1987