



Allergy, Asthma, Arthritis  
Center of Central Florida

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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

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