



Allergy, Asthma, Arthritis
Center of Central Florida

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ACKNOWLEDGEMENT

Yo, _____ (paciente/padre o encargado), certifico que he
recibido una copia sobre la privacidad y el manejo personal de la información de salud de la
oficina del Dr. José Andrade.

Nombre

Fecha de Nacimiento.

(Firma del paciente/padre o encargado)

Fecha

Nombre del Testigo

Firma del Testigo

Acknowledgement Spanish Rev. 01/2014

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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