



**Allergy, Asthma Immunology Care**

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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  
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