

**Allergy, Asthma & Immunology Consultants, Inc.**  
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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient or Patient's Representative  
Print Patient's Name: \_\_\_\_\_  
If signed by Representative, state name of  
Representative: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_