

COLUMBO ASTHMA, ALLERGY AND IMMUNOLOGY, L.L.C.

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I \_\_\_\_\_ (PATIENT) ACKNOWLEDGE THAT  
I AM AWARE OF THE NOTICE REGARDING PRIVACY OF PERSONAL HEALTH  
INFORMATION.

DATE \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

I HEREBY AUTHORIZE THE FOLLOWING PERSON(S) TO RECEIVE MEDICAL INFORMATION  
ON MY BEHALF:

NAME \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

NAME \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_