

Genesis Family Care, P.A.
Elizabeth Alvarez, M.D., P.A.

Acknowledgment of Receipt of Notice of Privacy Practices and Patient's Rights and Responsibilities

I, _____ acknowledge that I have
Patient's Full Name

Received a copy of the "Notice of Privacy Practices" and "Patient's Rights and Responsibilities" to read and that I fully understand its contents as written. I have also been provided with information regarding the procedures to follow when filing a complaint to the Texas Department of Insurance or the Texas Board of Medical Examiners.

Patient or Responsible Party's Signature

Date