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

Consent For Prescription History

I, ____ ________________

Patient's Name DOB

Willfully give permission to Genesis Family Care, P.A. and Elizabeth Alvarez, M.D., P.A. to obtain my prescription history from my pharmacies. I understand that this will allow my doctor to manage my medications better, would improve my safety and help to decrease possible medication errors.

____

Patient or Guardian's Signature

____

Date

Revised 2/2013