MEDICAL ASSOCIATES OF RHODE ISLAND, INC.

AUTHORIZATION TO DISCUSS/LEAVE MESSAGE REGARDING PERSONAL PROTECTED HEALTH INFORMATION

I, ______________________________________, DOB, ________________ give

Dr.: _____________________________ and his/her staff permission to discuss my personal protected health information with the following person(s):

Name: ______________________________ Tel#: _______________

Relationship to Patient: ________________________________

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Name: ______________________________ Tel#: _______________

Relationship to Patient: ________________________________

_______ *Yes, information regarding HIV, sexually transmitted disease or mental health issues may be discussed.*

_______ *No, information regarding HIV, sexually transmitted disease or mental health issues may NOT be discussed.*

AND/OR

_____ Yes, I give permission to leave my personal protected health information such as lab or test results on my phone voice mail.

_____ No, I do not give permission to leave my personal protected health information such as lab or test results on my phone voice mail.

This authorization will remain in place from the date signed or until I submit notification in writing to revoke or change.

____________________________________ _________________

Signature of Patient Date

____________________________________ _________________

Signature of MARI Provider/Staff Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all steps to form. There may be a processing fee associated with this request.

EACH SECTION OF FORM MUST BE CHECKED TO BE COMPLETE (except for # 6)

Completed	Section	
☐	1	**PATIENT INFORMATION: *(PLEASE PRINT)*** Patient Name: ________________________ Date of Birth: __________ Address: ____ Street City State Zip Code Home Phone: ______________ Cell/Daytime Phone: ______________
☐	2	**AUTHORIZATION** I, ________________________ hereby authorize. Physician Name: ________________________________ Address: ________________________________ ________________________________ to release my protected health information to: Name: ________________________________ Address: ________________________________ ________________________________ as set forth: □ Entire Record, including secondary records and consultation notes □ Only Dates of Treatment: ____________ to ____________ □ Only Medical Data/Information related to: □ Specific condition: ________________________ □ Specific service: ________________________ □ Specific medication: ________________________ □ Other: ________________________
☐	3	**SIGNATURE** I understand my records are protected under the federal and state privacy laws and cannot be disclosed without my written. consent except as otherwise specifically provided by law. I also understand that this authorization is valid for one (1) year and may be revoked at any time in writing, except to the extent that action has already been taken prior to the revocation date. All revocations must be sent to Medical Associates of RI, Inc. to the attention of the Privacy Officer for approval. Additional authorization for re-disclosure beyond recipient is required. **Patient (or Parent/Guardian) Signature: ________________Date__________** **Witness Signature: ________________________________**
☐	4	**SENSITIVE INFORMATION** I understand that if my medical record contains protected health information in regard to drug and/or alcohol abuse **(including 42CFR Part 2 information)** psychiatric, sexually transmitted disease, social service, hepatitis b testing/ treatment, and/or sensitive information: □ I am agreeing to its release: ________________________ □ I **DO NOT** want the following sensitive information released: ____________ ____ **Patient (or Parent/Guardian) Signature: ________________________**
☐	5	**RELEASE OF HIV INFORMATION** In addition to the above signatures, if you **DO WANT** your HIV (AIDS) testing/treatment records released you must sign and date on The line below: **Patient (or Parent/Guardian) Signature: ________________Date__________**
☐	6	**Consent to Photograph** I authorize and consent to the making of photographs of me while I am a patient at Medical Associates of RI, Inc. for the use of treatment purposes. I hereby release MARI from all liability related to the making of such photographs. **Patient (or Parent/Guardian) Signature: ________________________ Date: __________**

Revised 02/20

Medical Associates of Rhode Island
Medical History Form

Name *(Last, First, M.I.):* ______________________ ☐ M ☐ F **DOB:** ______________

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Adopted** ☐ Yes ☐ No

Emergency Contact ______________________ **Telephone Number** ______________

Occupation ____________ **Employer** ______________ **Telephone Number** ____________

Children Names/Ages ______________________________________

Previous or referring doctor: ______________________ **Date of last physical exam:** ____________

Advanced Directives: ☐ **Yes** ☐ **No** **Date of Review:** ____________ **Patient P.O.A.:** ______________

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other:____________

Immunizations and dates:			
	☐ Tetanus ________	☐ Pneumovax ________	☐ Zoster (shingles) ________
	☐ Hepatitis A ________	☐ Hepatitis B ________	☐ Chickenpox ________
	☐ Influenza ________	☐ HPV ________	☐ MMR *Measles, Mumps, Rubella* ________
Last TB test	________ Positive ☐ Yes ☐ No	Additional ________	☐ Meningitis ________

Please check if you currently have or have had any of the following

☐ Hypertension	☐ Fissures	☐ Depression	☐ Bleeding Disorder	☐ Coronary Artery Disease	☐ Sleep Apnea
☐ COPD	☐ Ulcers	☐ Blood Clots	☐ Heart Disease	☐ Diverticulitis	☐ Prostate Disease
☐ Asthma	☐ Heartburn	☐ Diabetes	☐ Thyroid Disease	☐ Kidney Disease	☐ Pneumonia
☐ Cancer	☐ Hay fever	☐ Migraines	☐ Colon Polyps	☐ Kidney Stones	☐ Hepatitis *A, B, C* ________
☐ Seizures	Type____________		☐ Psychiatric Disorder	☐ Elevated Cholesterol	☐ Fractures

Past Surgeries and Hospitalizations (Please list with approximate dates/reasons)

Surgeries/Hospitalizations	**Date**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency	Name the Drug	Strength	Frequency

MARI Medical Health Form revised 07/2014 Adult Medicine General Practice

ALLERGIES to medications	
Medication You Are Allergic to:	**Reaction You Had:**

Females Only Current method of Birth Control: ________________ Has your husband had a vasectomy? ☐ Yes ☐ No

Total # of Pregnancies _________ Live Births:__________ Miscarriages/Abortions: __________________

Last Menstrual Period _________ Age Beginning Periods __________ Age End of Periods __________

Family History (Blood relatives only)

Father	☐ Alive ☐ Deceased	History of: **CAD HTN CA DM**	Present health or cause of death:_____________	Age? _______
Mother	☐ Alive ☐ Deceased	History of: **CAD HTN CA DM**	Present health or cause of death:_____________	Age? _______
Brothers	____ # Alive ____ # Deceased	History of: **CAD HTN CA DM**	Present health or cause of death:_____________	Age? _______
Sisters	____ # Alive ____ # Deceased	History of: **CAD HTN CA DM**	Present health or cause of death:_____________	Age? _______

Immediate Family Medical Complaints (please check the medical problems immediate family members have or have had in the past.

Medical Complaint	Father	Mother	Siblings	Comments - Age	Medical Complaint	Father	Mother	Siblings	Comments - Age
Heart Attack	☐	☐	☐		Osteoporosis	☐	☐	☐	
High Blood Pressure	☐	☐	☐		Kidney Disease	☐	☐	☐	
Diabetes	☐	☐	☐		Brain Aneurysm	☐	☐	☐	
Cancer (list type)	☐	☐	☐		Blood Clots	☐	☐	☐	
Stroke	☐	☐	☐		Colon Polyps	☐	☐	☐	
Glaucoma	☐	☐	☐		Depression	☐	☐	☐	
Thyroid Disease	☐	☐	☐		High Cholesterol	☐	☐	☐	

Social History

Tobacco ☐ Yes ☐ No Packs per day:___ Yrs.___	Former Smoker ☐ Yes ☐ No Date Quit:____________________
Alcohol ☐ Yes ☐ No Drinks per week:______________	Exercise ☐ Yes ☐ No Times per week:____________________
Recreational Drugs ☐ Yes ☐ No Type:______________	Religious Preference (optional):____________________
Sexual Orientation: ________________________	Do religious beliefs impact your daily activities? ☐ Yes ☐ No

Comments: ____

Please Complete	
Little interest or pleasure in doing things?	☐ (0) Not at all ☐ (1) Several days ☐ (2) More than half the days ☐ (3) Nearly every day
Feeling down, depressed or hopeless?	☐ (0) Not at all ☐ (1) Several days ☐ (2) More than half the days ☐ (3) Nearly every day

Date of Last Preventive			**Safety**
Colonoscopy	Year_______	Normal? ☐ Yes ☐ No	Seatbelt Use ☐ Yes ☐ No Smoke Detector in Home ☐ Yes ☐ No
Mammogram	Year_______	Normal? ☐ Yes ☐ No	Firearm Use ☐ Yes ☐ No Recent Falls ☐ Yes ☐ No
Dexascan	Year_______	Normal? ☐ Yes ☐ No	Other (please explain) ____________________
PAP	Year_______	Normal? ☐ Yes ☐ No	

Preferred Pharmacy

Name: ____________________ Address: ______________________________ Telephone: ________________