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: _________________________________

****

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

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

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: ________________

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 ☐ 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. A 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 regards 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 08/17