OCEAN STATE MEDICAL, LLC

OCEAN STATE MEDICAL PRIVACY POLICY

1. All patient information is confidential.
2. Every attempt will be made to respect confidentiality when communicating with patients.
3. Patients will be informed of this policy upon entering the practice yearly thereafter.
4. It is our policy to release patient information to other providers only with written patient consent.
5. Only patients themselves may call for test results unless they have authorized us to give information to family members.
6. Employees will review this policy upon hiring and yearly thereafter.

TO PATIENTS:

At times the office may need to contact you regarding:

Test Results
Insurance Claims
To Confirm Appointments

If we call and you are not available:

May we leave a message on an answering machine at home? ☐ Yes ☐ No
May we leave a message on an answering machine at work? ☐ Yes ☐ No

May we leave a message with a family member? ☐ Yes ☐ No
May we leave a message with a co-worker? ☐ Yes ☐ No

If yes name of person: _____

Please indicate the best telephone number for us to reach you: _____

Patient signature: _____ Date: _____

Please Print Name: _____

OCEAN STATE MEDICAL, LLC

1539 Atwood Avenue, STE 101
Johnston
Rhode Island
02919

Fred F. Ferri, MD
Frank Savoretti, JD, MD
Alberto R. Savoretti, MD

Phone:
(401) 272-3410

(401)272-3417 FAX

*******PLEASE FAX ALL RECORDS TO THIS OFFICE*******

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient _____ DOB _____

Address _____ Phone # _____

_____

_____ SSN _____

Transfer the following info to:

Ocean State Medical, L.L.C.
1539 Atwood Ave, Suite 101
Johnston, RI 02919

Receive the following info from:

_____

_____

( ) Complete records
( ) Consultation notes
( ) Other _____

( ) Laboratory notes
( ) X-ray reports

This authorization includes allowing the transfer of information regarding:
( ) AIDS (Acquired Immunodeficiency Syndrome)
( ) HIV (Human Immunodeficiency Syndrome)
( ) Psychiatric disorders
( ) History of treatment for drug or alcohol abuse
( ) Other _____

I understand that this authorization may be revoked at any time prior to an actual release of records made in good faith that occurred in reliance on this authorization. This authorization will automatically expire in 90 days from the date below.

The purpose of this request is: _____

THIS AUTHORIZATION DOES NOT ALLOW AN AGENCY RECEIVING RECORDS FROM FURTHER DISTRIBUTING THEM WITHOUT ADDITIONAL WRITTEN CONSENT OF THE PATIENT.

Signed _____ Date: _____

Witness _____