Rhode Island Quality Institute

currentcare
Powering your health information
A service of Rhode Island Quality Institute

ENROLLMENT/AUTHORIZATION FOR RELEASE OF AND ACCESS TO HEALTH INFORMATION VIA CURRENT*CARE*

Patient First Name: Middle Name:

Patient Last Name:

Patient Date of Birth: (Example: 01/01/2001) Patient E-mail:

Patient Address:

City: State: Zip Code:

Phone Number: Gender: M F Other

Previous Name:

I have received the current***care*** brochure which explains how current***care*** helps make my health information available through a computer network to hospitals, nursing homes, physicians, laboratories and other health care providers participating in current***care***. I want this information to be released to support my care and treatment. If I have any questions, I can call the current***care*** Help Line: 1-888-858-4815 or visit the website: www.currentcareri.com.

I want to enroll in current***care***. I understand that health information is protected under federal privacy laws and regulations and under the General Laws of Rhode Island. By signing this form, I am authorizing health care providers treating me to provide my health information to current***care***. I also authorize **current*care*** to allow physicians, nurses, other health professionals, and/or their staff – whom I have specified below – to access my health information, in the course of helping me with my health care. They may make this information part of their medical record. I understand that all of my health information may be available in **current*care***, including information related to alcohol and substance abuse, mental or behavioral health, HIV/AIDS, genetic diseases or tests, and sexually-transmitted diseases.

I understand that once my health information is accessed through **current*care*** by the healthcare providers that I have authorized, **current*care*** cannot be responsible for the subsequent handling of the information. While existing federal and state privacy and confidentiality laws, including HIPAA, generally require my providers to protect my health information, in some cases (such as in response to a subpoena) these laws may not apply. Should a healthcare provider re-release information originally accessed through **current*care***, I release the Rhode Island Quality Institute from all liability arising from this redisclosure of my health information by others.

I am voluntarily choosing to enroll in current***care*** and understand that I can revoke this authorization at any time by filling out and submitting a *Revocation of Authorization* form to current***care***. Such revocation, however, will not affect disclosures made or access to the information while my authorization was in effect and will not prevent future re-disclosures of that information by health care providers and professionals who received information from current***care*** pursuant to this authorization prior to my revocation.

I understand that this authorization will expire if and when current***care***, or its successor organization(s), no longer exists.

Check <u>ONE</u> <u>box</u> below:

☐	I authorize any and all health care providers/organizations who are treating me or are involved in the coordination of my health care to access any and all of my health information through current***care***;

OR

☐	I authorize the following health care providers/organizations to have access to my health information through current***care***: (for this box fill in the requested information below)

Provider/Organization Name:

Provider Address:

City: State: Zip:

Provider Phone Number:

Provider Name:

Provider Address:

City: State: Zip:

Provider Phone Number:

Provider Name:

Provider Address:

City: State: Zip:

Provider Phone Number:

OR

☐	I authorize any and all health care providers/organizations access to my health information through current***care*** only in an emergency or unscheduled event on a temporary basis.

<u>Authorized Release and Access to Health Information in an Emergency or Unscheduled Event</u>. I understand that by enrolling in current*care*, my health information always may be accessed in an emergency or unscheduled event on a temporary basis.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Name of Authorized Representative (Please Print) Relationship

_____ _____

Name of Authenticator/Enroller (Please Print) Date