☑ Please choose ONLY ONE OPTION BOX below.

OPTION #1: ALL OF MY DOCTORS, INCLUDING EMERGENCY SITUATIONS

☐ 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 **currentcare**.

OR

OPTION #2: ONLY EMERGENCY SITUATIONS

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

OR

OPTION #3: ONLY SOME OF MY DOCTORS, AND EMERGENCY SITUATIONS

☐ I authorize the following health care providers/organizations to have access to my health information through **currentcare**. (If you selected this option, you must fill in the requested information below.)

If you selected Option #3 above, please fill out the information below. You only need to fill in this section if you selected Option #3.

Provider/Organization Name:

Provider Address:

City: State: Zip:

Provider Phone Number: - -

Provider/Organization Name:

Provider Address:

City: State: Zip:

Provider Phone Number: - -

Provider/Organization Name:

Provider Address:

City: State: Zip:

Provider Phone Number: - -

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

currentcare has been made possible through a joint effort by the Rhode Island Quality Institute and the Rhode Island Department of Health, with financial support from the federal government and other members of the health care community. The Rhode Island Quality Institute (RIQI) is Rhode Island's Regional Health Information Organization (RHIO). For more information about the Rhode Island Quality Institute, visit the RIQI website at www.RIQI.org.

Your health information...
when it's needed most.

currentcare
P.O. Box 28122
Providence, Rhode Island 02908
(888) 858-4815
info@currentcareri.com

www.currentcareri.com

currentcare connects your doctors with your most up-to-date health information so you can receive the best possible care.

All policies related to **currentcare** are available online at www.RIQI.org.

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SAFER Signing up for **currentcare** will help your doctors get your most up-to-date information right away so they can treat you with the best possible care. If you are ever in a medical crisis, emergency room doctors will be able to access more of your health information quickly through **currentcare**.

BETTER CARE Because you see a number of doctors, get different prescriptions, and get lab tests at different locations, it's hard to coordinate all aspects of your health care. **currentcare** will allow your doctors to see more of your health information in one place so they can give you the best possible care.

FREE Signing up for **currentcare** is free and completely voluntary. You decide if you want to participate and which of your doctors have access to view your secure health information.

For more information, call (888) 858-4815.

To participate, simply complete the attached form to give your doctors permission to access your health information through **currentcare** when they need it.

Today **currentcare** shares test results from medical laboratories. Over time it will include more of your health information, like your medications, X-rays and medical history.

www.currentcareri.com

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For office use only.

Please fill in your patient information below:

First Name: Middle Name:

Last Name: Date of Birth: m m - d d - y y y y

Address:

City: State: Zip: Gender: ◯ Male ◯ Female ◯ Other

Phone Number: - - E-mail:

Previous Name:

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

I want to sign up for **currentcare**. 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 **currentcare**. I also authorize **currentcare** to release and provide access to my health information to health care providers/organizations and professionals who are treating me or are involved in the coordination of my health care, are participating in **currentcare** and whom I have so authorized on the reverse side of this form.

I understand that by signing this authorization form, that it allows disclosure of and access to all my health information, including information relating to alcohol and substance abuse, mental or behavioral health, HIV/AIDS, genetic diseases or tests, and sexually transmitted diseases. If health information about me includes any of these types of information, I specifically authorize the release of such information to **currentcare** and access to such information by the authorized health care providers and professionals listed on the reverse side of this form.

I understand that authorized health care providers/organizations and professionals that receive or access health information about me from **currentcare** pursuant to this authorization may re-disclose this information to health care providers/organizations not participating in **currentcare** and/or for reasons unrelated to the coordination of my health care and treatment. It is possible that this health information may be re-disclosed to a person or entity that is not a health care provider covered by federal privacy regulations, and therefore, is no longer protected by those regulations (such as pursuant to a subpoena).

I release **currentcare** from all liability arising from the re-disclosure of my health information by others.

I am voluntarily choosing to sign up for **currentcare** and understand that I can revoke this authorization at any time by filling out and submitting a Revocation of Authorization form to **currentcare**. 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 **currentcare** pursuant to this authorization prior to my revocation.

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

Authorized Release and Access to Health Information in an Emergency or Unscheduled Event. I understand that by enrolling in currentcare, 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 _____

YOU MUST SELECT AN OPTION ON THE REVERSE SIDE. →