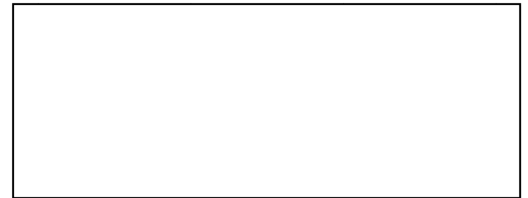
Rhode Island Quality Institute



Please <u>PRINT</u> or <u>TYPE</u> your patient information below:

First Name: ____________________ Middle Name: ____________

Last Name: ____________________ Date of Birth: ____ ____ ____ (MM DD YYYYY)

Address: ____________________
(NO P.O. Boxes)

City: ____________ State: ______ Zip: ______

Gender: ◯ Male ◯ Female ◯ Other

Phone Number: ____________ E-mail: ____________

Previous Name: ____________________

Name of Authorized Representative (if applicable): ____________________

Authorized Representative's relation to patient: ◯ Parent ◯ Legal Guardian ◯ Power of Attorney

☑ **Please choose <u>ONLY ONE OPTION BOX</u> 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 <u>EMERGENCY</u> 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: ______

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 questions, I can call the CurrentCare Information Line: 1-888-858-4815 or visit the website: www.currentcareri.org.

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 and that federal and Rhode Island law will be followed for the access, use and disclosure of my health information. 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, I am allowing 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, sickle cell anemia 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 have had the opportunity to access the list of participating provider organizations that are accessing health information in CurrentCare before providing this consent and signing this enrollment form.

I understand 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 (see provider list on currentcareri.com) not participating in CurrentCare and /or for reasons unrelated to the coordination of my health care and treatment if it is allowed by law. 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 or state privacy laws, and therefore, is no longer protected by those laws (such as pursuant to a subpoena).
I release CurrentCare from all liability arising from 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 Cancellation of Enrollment 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 exist.

If I am enrolling my minor child in CurrentCare, I understand and agree that when my child is between 10 and 18 years old that CurrentCare will not disclose HIV/AIDS, communicable diseases, abortion, substance abuse or family planning information to me. I also understand and agree that if my child is between 16 and 18 years old, or if my child is married, and my child consented to treatment for routine emergency or surgical care, CurrentCare will not disclose such information to me.

____ ________________

Signature of Patient or Authorized Representative Date

____

Printed name of Patient or Authorized Representative

____ ________________

Printed Name of Authenticator or Notary Date