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

REVOCATION (CANCELLATION) OF AUTHORIZATION: PATIENT ENROLLMENT

Patient Name	Date of Birth	Gender
Patient Address Street: City: State: Zip Code:		
Telephone Number	Cell Phone Number	Email

1. **Revocation of Authorization**. I previously authorized the release of my health information through **current*care*** by signing an Enrollment and Authorization Form. I have changed my mind and would like to revoke (cancel) my authorization at this time. By signing this *Revocation of Authorization Form*, I am hereby cancelling my authorization for any of my health information to be released, accessed or shared through **current*care***, even in an emergency or unanticipated health event.
2. **Effective Date of Revocation**. This revocation of my authorization will become effective when it is received by **current*care*** and recorded in the **current*care*** health information exchange system. This revocation of my authorization will not affect previous disclosures or access to my health information while my authorization was in effect.
3. **Voluntary Participation**. I understand that I participated in **current*care*** voluntarily and my revocation of authorization means I no longer want to participate in **current*care***. I am signing this Revocation voluntarily.
4. **Effect of Revocation**. I understand that because I will not be participating in **current*care***, my health information will not be released by **current*care*** to any hospital, physician or other health care provider even if I have an emergency medical condition (e.g., I am unconscious following a car accident and taken by ambulance to a hospital emergency room).

All items on this form have been completed and my questions about this form have been answered. I hereby revoke my authorization to participate in **current*care***.

✓_____ _____ Date _____

Signature of Patient ***(or Authorized Representative)*** **Printed Name of Health Care Provider/ Facility where signed & NPI#**_____

Authorized Representative.
Print name of Authorized Representative:_____

Authority to sign on behalf of patient (*e.g., health care power of attorney, guardian, parent of minor*):_____

If the Patient or Authorized Representative does not sign this ***Revocation of Authorization Patient Enrollment Form*** at a health care provider's facility or office, then the signature of the Patient or Authorized Representative must be notarized below.

_____ Date: _____

Notary Public *Date of Expiration of Commission* *(Affix Seal Here)*

Please complete this form sign and submit originals to:

current*care* *c/o Rhode Island Quality Institute, 235 Promenade Street, Suite 600, Providence, RI 02908*

Facsimiles (fax) and copies will not be accepted.