

## CurrentCare for Me Designee Form

By completing this form you are granting Designee access to your health record through CurrentCare for Me and/or access to Alerts only, based on the levels described and selected below.

- The individual must be enrolled in CurrentCare and be 18 years of age or older.
- A Designee can be any other person over 18 years of age designated by the individual to view this individual's medical record.

### Individual/Patient (please complete ALL fields)

This request applies to the following individual's medical record in CurrentCare for Me:

_____		_____		_____	
First Name		Middle Name		Last Name	
_____				( _____ )	_____ - _____
Street Address				Phone†	
_____	_____	_____ / _____ / _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Transgender <input type="checkbox"/>
City/Town	State	ZIP Code	Date of Birth		

- I want online access to my own health record through CurrentCare for Me, if I do not already have access. (Watch for a welcome email with directions to activate the account.)

\_\_\_\_\_ **Email Address (Required to view your own record)**

### Designee Information (please complete ALL fields)

Please check **ONE** box to grant this person **Designee** access to the above-named individual's CurrentCare for Me record. **Designee Alerts** allow Designees to receive email and/or text notifications when loved ones are admitted to, or discharged from, participating hospitals and skilled nursing facilities. Please check a box below for your Designees Access rights:

- A Designee with **Full Access** can view another person's CurrentCare for Me record, make modifications to the account (add designees, enable designee alerts, etc.) and receive Designee Alerts.

- OR -

- A Designee with **Alerts Only Access** can receive Designee Alerts, but cannot view another person's CurrentCare for Me record or make modifications to the account.

Grant this person access to the above-named individual's CurrentCare for Me record:

_____		_____		_____	
First Name		Middle Name		Last Name	
Street Address					
_____	_____	_____ / _____ / _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Transgender <input type="checkbox"/>
City/Town	State	ZIP Code	Date of Birth		

( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Phone † \_\_\_\_\_ **Email Address (Required for CurrentCare for Me)** We will send a message to the email address provided with directions to activate Designee access to CurrentCare for Me.

Designee's relationship to above-named **Individual/Patient**: (Choose One)

- Spouse  Father  Mother  Daughter  Son  Partner  Other (please list): \_\_\_\_\_

† By submitting a telephone number to RIQI you agree that a representative of RIQI can contact you at the number provided, potentially using automated technology (including texts/SMS messaging), or a pre-recorded message. Your consent to contact you at the telephone number(s) provided using automated or prerecorded messages, and text messages, is not required in order to participate in CurrentCare.

**Please complete and sign form on back!**

