For office use only

Enrollee Request to Amend Consent Form

CurrentCare Enrollee Name: First/Middle/Last	Date of Birth ___/___/___	Gender ☐ Male ☐ Female ☐ Other
Enrollee/Patient Address Street:		
City	State	Zip Code
Telephone Number	Cell Phone Number	Email

1. **Request to Amend Consent**. I authorize the state designated Regional Health Information Organization, the Rhode Island Quality Institute (RIQI), to amend my consent as described below.

2. **Effective Date of Request**. This request will become effective when it is received by RIQI and recorded in CurrentCare.

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 condition of my health 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.)***

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:

For your protection, we require that the "Enrollee Request to Amend Consent" form be authenticated by your physician's office staff if they are a CurrentCare enrollment partner, by a notary public or by a member of the Operations Department at Rhode Island Quality Institute.

I hereby certify that all items on this form have been completed to the best of my knowledge.

Print Name of Patient or Authorized Representative

Date

Signature of Patient or Authorized Representative

Relationship (select one)

- ☐ Parent
- ☐ Legal Guardian
- ☐ Power of Attorney

Print Name of Authenticator or Notary

Date

Please complete and sign this form and mail or hand-deliver the original form to:

CurrentCare
Rhode Island Quality Institute
50 Holden Street, Suite 300
Providence, RI 02908

Facsimiles (fax) and copies will not be accepted.