

currentcare
REVOCAION (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 **currentcare** 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 **currentcare**, 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 **currentcare** and recorded in the **currentcare** 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 **currentcare** voluntarily and my revocation of authorization means I no longer want to participate in **currentcare**. I am signing this Revocation voluntarily.

4. Effect of Revocation. I understand that because I will not be participating in **currentcare**, my health information will not be released by **currentcare** 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 **currentcare**.

Signature of Patient or Authorized Representative

Printed Name of Health Care Provider/
Facility where signed NPI#_____

Date: _____

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.

Notary Public

Date of Expiration
of Commission

Date: _____

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

currentcare
c/o Rhode Island Quality Institute
235 Promenade Street, Suite 540
Providence, RI 02908

Facsimiles (fax) and copies will not be accepted.