current care

Rhode Island Quality Institute

CurrentCare Enrollment Form

First Name | Middle Name | Last Name

Previous Name

Phone* ( ) -

Street Address (No PO Boxes)

Mobile* ( ) -

City/Town | State | ZIP Code | Date of Birth / /

Gender: Male ☐ Female ☐ Transgender ☐

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

YES! **I want online access my own health records!**

Watch for a welcome email with directions to activate the account.

Checking the '**YES**' box will create a CurrentCare for Me account for the email address provided above.

REQUIRED: Please choose only ***ONE*** option below to whom health information may be disclosed:

☐ **OPTION #1:** ALL OF MY DOCTORS, INCLUDING EMERGENCY SITUATIONS AND MY HEALTH PLAN AS ALLOWED BY LAW
I authorize any and all health care providers/organizations that are treating me now or may treat me in the future or are involved in the coordination of my healthcare and my health plan as allowed by law to access any and all of my health information through CurrentCare.

☐ **OPTION #2:** ONLY EMERGENCY SITUATIONS AND MY HEALTH PLAN AS ALLOWED BY LAW
I authorize any and all healthcare providers/organizations that are treating me now or may treat me in the future to access my health information through CurrentCare only in an emergency or unscheduled event on a temporary basis and my health plan as allowed by law.

☐ **OPTION #3:** SOME OF MY DOCTORS IN EMERGENCY SITUATIONS AND MY HEALTH PLAN AS ALLOWED BY LAW
I authorize the following healthcare providers/organizations to access my health information through CurrentCare and my health plan as allowed by law.. (If you select this option, the healthcare provider(s)/organization(s) you choose will only be allowed to access your information in emergency situations. Please fill in the requested information below.)

If you selected **OPTION #3** above, please complete this section:

Provider Organization Name

Provider Address | City | State | ZIP Code

Provider Organization Name

Provider Address | City | State | ZIP Code

* 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.

** To grant online access to another person, please complete a separate "CurrentCare for Me Designee Form." Access to CurrentCare for Me will only be granted to persons 18 years of age and older.

Please complete and sign form on back!

Rhode Island Quality Institute

Please read the agreement and complete registration by signing below:

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, other health care providers, and health plans 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. I understand that my health information may be collected but not accessed or disclosed to others without my consent. By signing this form, I am authorizing health care providers treating me now and in the future and health plans that I participate in now and in the future to provide my health information to CurrentCare. I also authorize CurrentCare to release and provide access to my health information to healthcare providers/organizations and professionals who are treating me now and in the future or are involved in the coordination of my healthcare, are participating in CurrentCare and I have authorized on the reverse side of this form. I also understand that by signing this authorization form, my health plan may access my health information as permitted by law for care management and/or for quality measure reporting purposes.

I understand that by signing this authorization form, I am allowing disclosure of and access to all of my health information, including information relating to alcohol and substance use disorder, 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 those I have authorized on the reverse side of this form, or as allowed by law. I have had the opportunity to access the list of participating provider organizations that may access my health information in CurrentCare before providing this consent and signing this enrollment form, and I understand that this list will change as new providers participate. I understand that I can access that list at currentcareri.org to see which providers and organizations participate and may have access to my substance use disorder information in the future. I understand that I am entitled to receive a List of Disclosures of my substance use disorder information provided to CurrentCare by a Part 2 program within the past two years by filling out a Request for List of Disclosures form, which is available at www.currentcareri.org.

I understand authorized health care providers/organizations, professionals and health plans that receive or access health information about me from CurrentCare pursuant to this authorization may re-disclose this information to other health care providers/organizations or health plans 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 or health plan 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 an Enrollment Cancellation 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 or health plans who received information from CurrentCare pursuant to this authorization prior to my revocation.

I understand that this authorization will expire upon my death or 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 use disorder 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

Authorized Representative Relationship:

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

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For Patient Name:

Questions? Visit our website at currentcareri.org or call 888-858-4815

FOR OFFICE USE ONLY — This section should not be completed by patients or authorized representatives

______________________________ ____/____/____

PRINTED Name of Authenticator or Notary — Date