For office use only

Cancellation of Authorization: Provider/Provider Organization Access 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. **Revocation of Authorization for Provider Organization Access.** I previously authorized the release of my protected health information to Provider Organization listed below through CurrentCare by signing an Enrollment and Authorization Form. I have changed my mind and would like to revoke (cancel) my authorization for Provider Organization listed below to access my health information at this time. By signing this Revocation of Authorization: Provider or Provider Organization Access Form, I am hereby cancelling my authorization for any of my health information to be released, accessed or shared through CurrentCare, except in an emergency or unanticipated health event, to Provider Organization listed below. However, any and all other Provider Organizations to whom I have authorized to access my health information may continue to access such information.

2. **Effective Date of Request.** This revocation of my authorization for Provider Organization listed below to access my health information will become effective when it is received by the state designated Regional Health Information Organization, the Rhode Island Quality Institute (RIQI), 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.

Provider or Provider Organization Information

Individual Provider or Provider Organization name	**Provider address**	**Provider telephone**
1.		
2.		

All items on this form have been completed and my questions about this form have been answered. I hereby revoke authorization to Provider or Provider Organizations listed above to access my health information.

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

For your protection, we require that the "Cancellation of Authorization: Provider or Provider Organization" 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

Relationship (select one)
☐ Parent
☐ Legal Guardian
☐ Power of Attorney

_____

Signature of Patient or Authorized Representative

_____ _____

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.