For office use only

CurrentCare Enrollment Cancellation

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.** I previously authorized the release of my protected 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 Enrollment Cancellation Form, I am hereby cancelling my authorization for any of my health information to be released, accessed, or shared through CurrentCare.

2. **Effective Date of Revocation.** This revocation of my authorization 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.

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 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.

For your protection, we require that the “Currentcare Enrollment Cancellation” 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.

____ ______________

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.