For office use only

ENROLLEE REQUEST for DISCLOSURE REPORT 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 for Disclosure Report**. I authorize the state designated Regional Health Information Organization, the Rhode Island Quality Institute (RIQI) to prepare a Disclosure Report outlining all disclosures of my health information to users of CurrentCare during the period specified below. I understand that the period of disclosures reported as a result of this request will not exceed the past six years.
2. **Effective Date of Request**. This request will become effective when it is received by RIQI and is confirmed to be complete. I understand that RIQI will make every effort to produce the requested report as soon as possible and no later than 60 days of a completed request or to make me aware of any cause for delay in my request. RIQI may also request a 30 day extension to produce the report. I understand that RIQI will review the effective date of this request and, if it has been less than 12 months since the last request for a report of disclosures of my health information, RIQI may require reasonable payment for this Report.
3. **Effect of Request**. As a result of this request, RIQI will provide a Report of Disclosures to the enrollee named above or their authorized representative. I hold RIQI harmless for any subsequent disclosure of this Report once it is released to the requestor.

Request for Disclosure Report from CurrentCare

I, _____ request a written Disclosure Report for the period from _____ to _____
Printed Name of Enrollee

Please give me my report in ☐ electronic format ☐ paper format

Delivered by: ☐ Mail to the enrollee address above ☐ Pick-up at RIQI office ☐ Secure email

For your protection, we require that the "Enrollee Request for Disclosure Report" 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.