Directions for Completing and Submitting this Form

If you feel the information in your CurrentCare record is not accurate, you can request that your provider submit a change to CurrentCare. Please note that CurrentCare cannot do this directly, and must receive electronic documentation from your provider.

To request that your provider make a change to your health information:

1. Please complete the form; attach extra pages if needed.

> If you need assistance completing the form,
> please call CurrentCare Support at **888-858-4815.**

2. Sign and date the form

3. Submit both pages of this form **to your provider**.

Please note: your provider may have additional forms to be completed before any changes can be made to your health record.

Directions for Treating Providers

Per HIPAA requirements and RI State Regulations, only the treating provider can make changes to a medical record, if warranted. Additionally, regulations state that a change is to be made (or denied) within 60 days of the patient's request. Because CurrentCare Data-Sharing Partners submit records electronically, any change would be updated in the HIE once the electronic record is received. To ensure that any changes were received into the HIE and applied to the patient record, please notify CurrentCare of your decision to make or deny the requested change by sending a secure email to CurrentCare at: Support@CurrentCareRI.org.

REQUEST TO AMEND HEALTH INFORMATION FORM

For Office Use Only

Patient Information

Name (*Please Print or Type*) *Last* *First* *Middle Initial*

Date of Birth: (mm/dd/yyyy): ___/___/_____ **Gender**: Male ☐ Female ☐ Other ☐

Address: _____

City: _____ **State**: _____ **Zip:** _____

Phone: (____) _____ **E-mail Address**: _____

Please describe the information in your CurrentCare Record that you would like to be changed:

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**

_____ _____

Signature *of Patient or Authorized Representative* **Date**