Directions for completing this form

- Print and complete the request form
  - *If you cannot print the form, call 888-858-4815 and request that it be mailed to you*
- Sign, date, and obtain authorization via a notary public
- Send the form to us by one of these methods:
  1) Mail to:

     Rhode Island Quality Institute
     Attn: HIPAA Compliance Officer
     315 Iron Horse Way, Suite 102
     Providence, RI 02908

  2) Drop it in the mail slot to the right of our suite door at the above address
  3) Make an appointment to bring the completed form to our office along with two forms of identification (if not notarized): 1 must be a photo ID

Need to submit a request by phone? Call 888-858-4815 to speak to one of our Client Services Representatives who will verify your identity and assist you in submitting a request form.

Note: If you are someone who makes healthcare decisions for this patient and are requesting a copy of a health record, you must verify by attaching a copy of the court order of legal guardianship or Durable Power of Attorney.

- **Effective Date of Request**. This request will become effective when it is received by the state-designated Regional Health Information Organization, the Rhode Island Quality Institute (RIQI). I understand that RIQI will provide a copy of my Record to me within thirty (30) days of my 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.

- **Effect of Request.** As a result of this request, RIQI will deliver a copy of the CurrentCare Record requested per the method I selected below. I hold RIQI and CurrentCare harmless for any subsequent disclosure of this Record when mailed to the address provided above or given to me in person.

current care®

Request to Access Health Information Form

CurrentCare Patient Information

_____

Patient 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**: _____

I am requesting a disclosure report for these dates: _____ to _____

Please provide my report in this format: ☐ electronic ☐ paper

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

If you are the patient:

I affirm that the information contained on this form is true and accurate.

Print Name clearly: _____

Signature: _____ Date: _____

If you are *not* the patient:

Please indicate your relationship to the patient: ☐a parent* ☐legal guardian* ☐Power of Attorney

Your Name : _____

Address: _____ City: _____State _____ Zip _____

Phone: _____ Email Address: _____

Note: Restrictions apply to disclosure of certain information related to minors

I affirm that the information contained on this form is true and accurate.

Print Name clearly: _____

Signature: _____ Date: _____

Authentication:

_____My commission expires: _____

Print Name of Notary or RIQI Representative

Signature: _____ Date: _____

For RIQI Use only: Verification was obtained by:

☐Correct Answers to Veritad ☐Verified two forms of ID ☐POA ☐Notary Public

Verified by RIQI Representative: _____