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
     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 change to the consent option, you must verify by attaching a copy of the court order of legal guardianship or Durable Power of Attorney.

1. **Request to Amend Consent**. I authorize the state designated Regional Health Information Organization, the Rhode Island Quality Institute (RIQI), to amend my consent as described below.

2. **Effective Date of Request**. This request will become effective when it is received by RIQI and recorded in CurrentCare.

REQUEST to AMEND CONSENT OPTIONS 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**: _____

Please select one option:

☐ **OPTION #1: ALL OF MY DOCTORS, INCLUDING EMERGENCY SITUATIONS -** I authorize any and all health care providers/organizations who are treating me or are involved in the condition of my health to access any and all of my health information through CurrentCare.

☐ **OPTION #2: ONLY EMERGENCY SITUATIONS -** I authorize any and all health care providers/organizations access to my health information through CurrentCare only in an emergency or unscheduled event on a temporary basis.

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: _____

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: _____