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

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

1. **Request for Accounting of Disclosures Report**. I authorize the Rhode Island Quality Institute (RIQI) to prepare an Accounting of Disclosures Report outlining all disclosures of my health information to users of CurrentCare during the period specified. 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 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 an Accounting of Disclosures Report to the enrollee named or their authorized representative or agent. I hold RIQI harmless for any subsequent disclosure of this report once it is released to the requestor.

REQUEST for DISCLOSURE REPORT 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:

☐Verified two forms of ID ☐POA ☐Notary Public

Verified by RIQI Representative: ____