



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 is requesting to cancel enrollment in CurrentCare, you must verify by attaching a copy of the court order of legal guardianship or Durable Power of Attorney.

1. **Revocation of Authorization.** I previously authorized the release of my protected health information through CurrentCare by signing an Enrollment and Authorization Form. I have changed my mind and would like to revoke (cancel) my authorization at this time. By signing this Enrollment Cancellation Form, I am hereby cancelling my authorization for any of my health information to be released, accessed, or shared through CurrentCare.
2. **Effective Date of Revocation.** This revocation of my authorization will become effective when it is received by the state designated Regional Health Information Organization, the Rhode Island Quality Institute (RIQI), and recorded in the CurrentCare health information exchange system. This revocation of my authorization will not affect previous disclosures or access to my health information while my authorization was in effect.
3. **Voluntary Participation.** I understand that I participated in CurrentCare voluntarily and my revocation of authorization means I no longer want to participate in CurrentCare. I am signing this Revocation voluntarily.
4. **Effect of Revocation.** I understand that because I will not be participating in CurrentCare, my health information will not be released by CurrentCare to any hospital, physician, or other health care provider even if I have an emergency medical condition (e.g., I am unconscious following a car accident and taken by ambulance to hospital emergency room).



CURRENTCARE ENROLLMENT CANCELLATION 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:

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:

All items on this form have been completed and my questions about this form have been answered. I hereby revoke my authorization to participate in CurrentCare.

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: