current care

Rhode Island Quality Institute

Quality Behavioral Health
75 Lambert Lind Highway
Suite 120-100
Warwick, RI 02886

CurrentCare / CurrentCare for Me Enrollment Form

First Name _____ Middle Name _____ Last Name _____

Street Address (No PO Boxes) _____ ( ) _____ - _____ Phone*

City/Town _____ State _____ ZIP Code _____ Date of Birth ___/___/___ ( ) _____ - _____ Mobile*

Email Address (Required for CurrentCare for Me) _____ Male ☐ Female ☐ Other ☐

☐ YES!

Please sign me up for CurrentCare for Me

- Checking this box will create a CurrentCare for Me account for the email address provided above.
- Watch for a welcome email with directions to activate the account.
- To grant online access to another person, please complete a separate "CurrentCare for Me Designee Form."
- Access to CurrentCare for Me will only be granted to persons 18 years of age and older.

REQUIRED: Please choose only ***ONE*** option below:

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

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

☐ **OPTION #3:** ONLY SOME OF MY DOCTORS, AND EMERGENCY SITUATIONS
I authorize the following healthcare providers/organizations to access my health information through CurrentCare. (If you select this option, you must fill in the requested information below.)

If you selected **OPTION #3** above, please complete this section:

Provider Organization Name _____

Provider Address _____ City _____ State _____ ZIP Code _____

Provider Organization Name _____

Provider Address _____ City _____ State _____ ZIP Code _____

*By submitting a telephone number to RIQI you agree that a representative of RIQI can contact you at the number provided, potentially using automated technology (including texts/SMS messaging), or a pre-recorded message.

Please complete and sign form on back!

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Please read the agreement and complete registration by signing below:

I have received the CurrentCare brochure which explains how CurrentCare helps make my health information available through a computer network to hospitals, nursing homes, physicians, laboratories and other health care providers, as well as health plans, participating in CurrentCare. I want this information to be released to support my care and treatment. If I have questions, I can call the CurrentCare Information Line: 1-888-858-4815 or visit the website: www.currentcareri.org.

I want to sign up for CurrentCare. I understand that health information is protected under federal privacy laws and regulations and under the General Laws of Rhode Island and that federal and Rhode Island law will be followed for the access, use and disclosure of my health information. By signing this form, I am authorizing health care providers treating me and health plans that I participate in to provide my health information to CurrentCare. I also authorize CurrentCare to release and provide access to my health information to healthcare providers/organizations and professionals who are treating me or are involved in the coordination of my healthcare, are participating in CurrentCare and I have authorized on the reverse side of this form. I also understand that by signing this authorization form, my health plan may access my health information as permitted by law for care management and/or for quality measure reporting purposes.

I understand that by signing this authorization form, I am allowing disclosure of and access to all of my health information, including information relating to alcohol and substance abuse, mental or behavioral health, HIV/AIDS, genetic diseases or tests, sickle cell anemia and sexually transmitted diseases. If health information about me includes any of these types of information, I specifically authorize the release of such information to CurrentCare and access to such information by the authorized health care providers and professionals listed on the reverse side of this form, or as allowed by law. I have had the opportunity to access the list of participating provider organizations that are accessing health information in CurrentCare before providing this consent and signing this enrollment form.

I understand authorized health care providers/organizations, professionals and health plans that receive or access health information about me from CurrentCare pursuant to this authorization may re-disclose this information to other health care providers/organizations (see provider list on currentcareri.com) or health plans not participating in CurrentCare and /or for reasons unrelated to the coordination of my health care and treatment if it is allowed by law. It is possible that this health information may be re-disclosed to a person or entity that is not a health care provider or health plan covered by federal or state privacy laws, and therefore, is no longer protected by those laws (such as pursuant to a subpoena). I release CurrentCare from all liability arising from re-disclosure of my health information by others.

I am voluntarily choosing to sign up for CurrentCare and understand that I can revoke this authorization at any time by filling out and submitting an Enrollment Cancellation form to CurrentCare. Such revocation, however, will not affect disclosures made or access to the information while my authorization was in effect and will not prevent future re-disclosures of that information by health care providers and professionals or health plans who received information from CurrentCare pursuant to this authorization prior to my revocation.

I understand that this authorization will expire if and when CurrentCare, or its successor organization(s), no longer exist.

If I am enrolling my minor child in CurrentCare, I understand and agree that when my child is between 10 and 18 years old that CurrentCare will not disclose HIV/AIDS, communicable diseases, abortion, substance abuse or family planning information to me. I also understand and agree that if my child is between 16 and 18 years old, or if my child is married, and my child consented to treatment for routine emergency or surgical care, CurrentCare will not disclose such information to me.

_____ ____/____/____

Signature of Patient or Authorized Representative or Power of Attorney Date

PRINTED Name of Patient or Authorized Representative or Power of Attorney

Authorized Representative Relationship:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Power of Attorney

_____

For Patient Name:

Questions? Visit our website at currentcareri.org or call 888-858-4815

FOR OFFICE USE ONLY — This section should not be completed by patients or authorized representatives

_____ ____/____/____

PRINTED Name of Authenticator or Notary Date