

**ENROLLMENT/AUTHORIZATION FOR RELEASE OF AND ACCESS TO HEALTH INFORMATION  
VIA CURRENTCARE**

Patient First Name: <input style="width: 100%; height: 20px;" type="text"/>	Middle Name: <input style="width: 100%; height: 20px;" type="text"/>	
Patient Last Name: <input style="width: 100%; height: 20px;" type="text"/>		
Patient Date of Birth: (Example: 01/01/2001) <input style="width: 100%; height: 20px;" type="text"/>	Patient E-mail: <input style="width: 100%; height: 20px;" type="text"/>	
Patient Address: <input style="width: 100%; height: 20px;" type="text"/>		
City: <input style="width: 100%; height: 20px;" type="text"/>	State: <input style="width: 100%; height: 20px;" type="text"/>	Zip Code: <input style="width: 100%; height: 20px;" type="text"/>
Phone Number: <input style="width: 100%; height: 20px;" type="text"/>	Gender:    M                      F                      Other <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/>	
Previous Name: <input style="width: 100%; height: 20px;" type="text"/>		

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 participating in **currentcare**. I want this information to be released to support my care and treatment. If I have any questions, I can call the **currentcare** Help Line: 1-888-858-4815 or visit the website: [www.currentcareri.com](http://www.currentcareri.com).

I want to enroll in **currentcare**. I understand that health information is protected under federal privacy laws and regulations and under the General Laws of Rhode Island. By signing this form, I am authorizing health care providers treating me to provide my health information to **currentcare**. I also authorize **currentcare** to release and provide access to my health information to health care providers/organizations and professionals who are treating me or are involved in the coordination of my health care, are participating in **currentcare** and whom I have so authorized below.

I understand that by signing this enrollment form, that it allows disclosure of and access to all my health information, including information relating to alcohol and substance abuse, mental or behavioral health, HIV/AIDS, genetic diseases or tests, 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 below.

I understand that authorized health care providers/organizations and professionals that receive or access health information about me from **currentcare** pursuant to this authorization may re-disclose this information to health care providers/organizations not participating in **currentcare** and/or for reasons unrelated to the coordination of my health care and treatment. It is possible that this health information may be re-disclosed to person or entity that is not a health care provider covered by federal privacy regulations, and therefore, is no longer protected by those regulations (such as pursuant to a subpoena). I release **currentcare** from all liability arising from the re-disclosure of my health information by others.

I am voluntarily choosing to enroll in **currentcare** and understand that I can revoke this authorization at any time by filling out and submitting a *Revocation of Authorization* 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 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 exists.

