Authorization for Use & Disclosure of Protected Health Information (PHI)

Name:		Date of Birth	
Address:			
City:		State:	Zip code:

I am enrolled in CurrentCare and wish for my health information to be disclosed to CurrentCare for providing me with treatment and/or coordination of care purposes. I hereby authorize _____ to **disclose** all of my health information, including my information relating to alcohol and substance abuse, mental or behavioral health, HIV/AIDS, genetic diseases or tests, and sexually transmitted diseases, to: **Rhode Island Quality Institute** as the administrator and operator of the Rhode Island statewide health information exchange CurrentCare.

I understand that my records are protected under federal and Rhode Island laws and regulations, and cannot be disclosed without my written consent, except as otherwise specifically provided by law. I understand that I may revoke (cancel) this authorization at any time and I must do so in writing at the address below. I understand that any revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not be effective until it is actually received and processed. I understand that signing this authorization is voluntary. I understand that pursuant to my CurrentCare enrollment form, my PHI may be re-disclosed only to the health care providers to whom I have given authorization to access my PHI and who acknowledge that they are treating me and need access to my PHI to treat me.

I understand that my PHI contains information involving treatment for alcohol or drug abuse, and are also protected under the federal regulation 42 CFR Part 2, and any disclosure of my information to CurrentCare by my substance abuse treatment provider will include a notification that CurrentCare may not redisclose my substance abuse treatment records without my consent, which shall be given only through my CurrentCare enrollment form.

Further, information released with this authorization will not be given, sold, transferred or in any way disclosed to any other entity unless authorized by law, without my further written consent.

This consent shall expire one (1) year from the date of this form unless otherwise specified below, or earlier terminated in writing by patient.

Specify Date (less than one year): _____

Signature of Patient / Legal Representative	Relationship to Client	Date

If patient has a legal guardian or is an emancipated minor, request copies of the legal documentation.

Signature of client if under 18

Signature **Date:**

<u>Facility Correspondence Address and Telephone Number</u>: