

currentcare
**REVOCATION (CANCELLATION) OF AUTHORIZATION:
PROVIDER OR PROVIDER ORGANIZATION ACCESS**

Patient Name	Date of Birth	Gender
Patient Address		
Street:	City:	State: Zip Code:
Telephone number	Cell Phone Number	Email

1. Revocation of Authorization for Provider Organization Access. I previously authorized the release of my health information to Provider Organization listed below through **currentcare** by signing an Enrollment and Authorization Form. I have changed my mind and would like to revoke (cancel) my authorization for Provider Organization listed below to access my health information at this time. By signing this *Revocation of Authorization: Provider or Provider Organization Access Form*, I am hereby cancelling my authorization for any of my health information to be released, accessed or shared through **currentcare**, except in an emergency or unanticipated health event to Provider Organization listed below. However, any and all other Provider Organizations to whom I have authorized to access my health information may continue to access such information.

2. Effective Date of Revocation. This revocation of my authorization for Provider Organization listed below to access my health information will become effective when it is received by **currentcare**, 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.

Individual Provider' or Provider Organization name	Provider address	Provider telephone
1.		
2.		
3.		

All items on this form have been completed and my questions about this form have been answered. I hereby revoke authorization to Provider Organizations listed above to access my health information.

*Signature of Patient or
Authorized Representative*

Printed Name of Health Care Provider/
Facility where signed & NPI# _____

Date: _____

Authorized Representative.
Print name of Authorized Representative: _____

Authority to sign on behalf of patient (e.g., health care power of attorney, guardian, parent of minor): _____

If the Patient or Authorized Representative does not sign this *Revocation of Authorization Form* at a health care provider's facility or office, then the signature of the Patient or Authorized Representative must be notarized below.

Notary Public

*Date of Expiration
of Commission*

Date: _____

Please complete and sign this form and mail or hand-deliver the original form to:

currentcare c/o Rhode Island Quality Institute 235 Promenade Street, Suite 600 Providence, RI 02908

Facsimiles (fax) and copies will not be accepted.