way to quit.org

Utah Tobacco Quitline Fax Form

Fax to: 1-800-483-3076

PROVIDER INFORMATION (PRINT CLEARLY)

Feedback will only be sent to **HIPAA covered entities** to either the fax number or email listed below.

Health Care Professional First Name _____ **Health Care Professional Last Name** _____

Clinic/Hospital Contact First Name _____ **Clinic/Hospital Contact Last Name** _____

Name of Organization/Hospital/Facility/Employer/Etc. _____

Name of Department or Clinic Name (if applicable):._____

Address _____

City_____**State**_____**Zip** _____

Phone(_____) _____ – _____ **Fax** (_____) _____ – _____ **Email:** _____

Type of HIPAA Covered Entity: Healthcare Provider☐ Health Plan ☐ Healthcare Clearing House ☐ Not Covered Entity ☐

As a HIPAA covered entity you are authorized to receive personal health information for the individual being referred.
As a Not Covered Entity, personal health information will not be shared back for the individual being referred.

Provider consent is required to provide nicotine replacement therapy (NRT) to individuals who are pregnant or breast feeding.

Is the patient? Pregnant☐ Breastfeeding☐

(If Provider) I authorize the QuitLine to send the patient over-the-counter nicotine replacement therapy.

Please sign here if patient may use NRT. _____ **Date** _____

Provider signature

PATIENT INFORMATION (*Required) (PRINT CLEARLY)

The information obtained through this form is used for program purposes only.
La información obtenida a través de este formulario será utilizada solamente para propósitos del programa.

***Patient Name** (First) _____ (Last) _____

Patient Zip _____ ***Date of Birth:** _____/_____/_____

***Phone** (_____) _____–_____ ☐ Home ☐ Cell ☐ Work

OK to leave message at number provided? ☐ Yes ☐ No
THE VOICEMAIL MAY BE A RECORDING FROM AN AUTODIALER.

***Do you require accommodation while participating in the program such as TTY, Translator or Relay Service?**

☐ No ☐ Yes If yes, please specify _____

Consent of Text: ☐ Yes ☐ No
I consent to receiving text messages with motivational messages and other program events, such as appointment reminders, medication shipments, and quit anniversaries.

***Language?** ☐ English ☐ Spanish ☐ Other _____

Insurance? None ☐ Medicare☐ Medicaid☐ Other☐ Name:_____

I, the patient (or authorized representative), give permission to release my information to the Utah Tobacco Quitline Program. The purpose of this release is to request an initial phone call to discuss my interest and participation in the tobacco cessation program and allow communication with the provider identified on this form. I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.

Yo, el/la paciente (o representante autorizado/a), doy permiso para que compartan mi información con el programa Utah Tobacco QuitLine. El objetivo de esta autorización es solicitar una llamada telefónica inicial para hablar sobre mi interés y participación en el programa para dejar el tabaco y permitir la comunicación con el proveedor identificado en este formulario. Puedo revocar esta autorización en cualquier momento por escrito; sin embargo, si la revoco, no afectará las medidas adoptadas antes de recibir la revocación.

***Patient Signature** _____ **Date** _____

If filling out form on behalf of the patient:

Authorized Representative name: (First)_____ (Last) _____

Signature _____ **Date** _____

**Participant or Authorized Representative signature required in order to place phone call to the patient.*

PLEASE FAX COMPLETED FORM TO: 1-800-483-3076