Quit Partner Fax Form

Fax to: 1-800-261-6259

PROVIDER INFORMATION (PRINT CLEARLY)

Feedback will only be sent to HIPAA covered entities to the fax number listed below.

Provider First Name ______________________________ **Provider Last Name** ______________________________

Contact First Name ______________________________ **Contact Last Name** ______________________________

Name of Health System/Hospital/Health Center/Community Organization: ______________________________

Name of Department or Clinic (if applicable): ______________________________

Address ______________________________

City______________________________**State**______________**Zip** ______________

Phone (_______) _________ – _________ **Fax for HIPAA covered entity** (_______) _________ – _________

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 have certain medical conditions or are pregnant.

Does the patient have any of the following conditions? 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 (PRINT CLEARLY)

Patient name (First) ______________________________ (Last) ______________________________

Address ______________________________

City______________________________**State**______________**Zip** ______________

Phone (_______) _________ – _________

Home ☐ Cell ☐ Work ☐

DOB_______/_________/_________

Language? ☐ English ☐ Spanish; ☐ Other ______________

OK to leave a message at number provided? Yes ☐ No ☐

Insurance? Yes ☐ No ☐

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

No ☐ Yes ☐ **If yes, please specify** ______________

Medicare ☐ **Medicaid** ☐

Other ☐ **Name:**______________________________

I, the patient (or authorized representative), give permission to release my information to Quit Partner. 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.

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: 1-800-261-6259

OR MAIL COMPLETED FORM TO: Quit Partner, National Jewish Health, 1400 Jackson St., S104A, Denver, CO 80206

Confidentiality Notice: This facsimile contains confidential information. If you have received this in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy or distribute.