



# QUIT PARTNER FAX REFERRAL FORM

Fax Number: 1-800-261-6259

## PROVIDER INFORMATION (PRINT CLEARLY)

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

Provider First Name \_\_\_\_\_ Provider Last Name \_\_\_\_\_

Organization Contact (if applicable): First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Name of Health System/Hospital/Health Center/Community Organization: \_\_\_\_\_

Department or Clinic Name (if applicable): \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email for HIPAA-covered entity \_\_\_\_\_

Fax for HIPAA covered entity (\_\_\_\_) \_\_\_\_-\_\_\_\_

Fax for HIPAA covered entity: Health care Provider Health Plan Health care 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 us NRT. \_\_\_\_\_ Date \_\_\_\_\_  
Provider signature

## PATIENT INFORMATION (\*Required) (PRINT CLEARLY)

\*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 AUTODAILER.

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

Yes,if yes, please specify \_\_\_\_\_  No

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 \_\_\_\_\_

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

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.