



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 _____

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 (_____) _____ - _____

Type of 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 Quit Partner 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)

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

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

THE VOICEMAIL MAY BE A RECORDING FROM AN AUTODIALER.

☐ Yes, if Yes, please specify _____ ☐ No

Consent of Text: ☐ Yes ☐ No

*Language? ☐ English ☐ Spanish

I consent to receiving text messages with motivational messages and other program events, such as appointment reminders, medication shipments, and quit anniversaries. Standard message rates may apply. Reply STOP to opt

Other _____

out.

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

Yo, el/la paciente (o representante autorizado/a), doy permiso para que compartan mi información con el programa Quit Partner. 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: 1-800-261-6259

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.