way to quit.org

Utah Quitline Fax Form

Fax to: 1-800-483-3076

PROVIDER INFORMATION (PRINT CLEARLY)

Feedback will only be sent to HIPAA covered entities to the fax number 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** (_______) _________ – ___________

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)

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) ____________________

Address ____

City______________________**State**____________**Zip** ____________

Phone (_______) _________ – ___________ **DOB**_______/_________/________

Home ☐ Cell ☐ Work ☐ **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 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 dar mi información al programa Utah Tobacco QuitLine. El propósito de este permiso es para solicitar una llamada telefónica inicial para charlar sobre mi interés y participación en el programa de cesación de tabaco y permitir la comunicación con el proveedor identificado en este formulario. Puedo revocar esta autorización en cualquier momento por escrito, pero si lo hago, no tendrá ningún efecto sobre 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

OR MAIL COMPLETED FORM TO: Utah Tobacco Quitline, 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.