



Quit Now Kentucky 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 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  Uncontrolled High Blood Pressure   
(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 (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ 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?

Medicare  Medicaid

Other  Name: \_\_\_\_\_

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

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

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 Now Kentucky, 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.