Wyoming Quit Tobacco Program 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 Clinic and Department/Organization/Hospital/Department/Facility/Employer/Etc.

_____

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)

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 Wyoming Quit Tobacco 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: Wyoming Quit Tobacco Program, 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.