QUITWORKS-RI

Rhode Island Nicotine Helpline Fax Form

Fax to: 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 Line 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)

***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 AUTODIALER.

***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:

I consent to receiving text messages with motivational messages and other program events, such as appointment reminders, medication shipments, and quit anniversaries.

☐ **Yes** ☐ **No**

***Language?** ☐ **English** ☐ **Spanish** ☐ **Other** _____

I, the patient (or authorized representative), give permission to release my information to the Rhode Island Nicotine Helpline for 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