MONTANA TOBACCO QUIT LINE
1-800-QUIT-NOW
1-800-784-8669

AMERICAN INDIAN Commercial Tobacco Quit Line
1 (855) 372-0037
MTAmericanIndianQuitLine.com

MY LIFE MY QUIT™
mylifemyquit.com
1-855-891-9989

# Montana Tobacco Quit Line Fax Form

**Fax to: 1-800-261-6259**

## PROVIDER INFORMATION (PRINT CLEARLY)

**Provider First Name** _____ **Provider Last Name** _____

**Contact First Name** _____ **Contact Last Name** _____

**Name of Clinic/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☐

**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 "Client Name" 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: Montana Tobacco Quit Line, National Jewish Health, 1400 Jackson St., S104A, Denver, CO 80206**