



FAX SENT DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Provider Information:

CLINIC NAME

CLINIC ZIP CODE

HEALTH CARE PROVIDER

CONTACT NAME

FAX NUMBER

PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)

YES

NO

DON'T KNOW

### Patient Information:

PATIENT NAME

DATE OF BIRTH

GENDER

MALE

FEMALE

ADDRESS

CITY

ZIP CODE

PRIMARY PHONE NUMBER

HM

WK

CELL

SECONDARY PHONE NUMBER

HM

WK

CELL

LANGUAGE PREFERENCE (PLEASE CHECK ONE)

ENGLISH

SPANISH

OTHER

\_\_\_\_ I am ready to quit tobacco and request Quitline Iowa contact me to help me with my quit plan.  
(Initial)

\_\_\_\_ I DO NOT give my permission to Quitline Iowa to leave a message when contacting me.  
(Initial) \*\* By not initialing, you are giving your permission for the quitline to leave a message.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Quitline Iowa will call you. Please check the BEST 3-hour time frame for them to reach you. **NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.**

6AM – 9AM

9AM – 12PM

12PM – 3PM

3PM – 6PM

6PM – 9PM

WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (CHECK ONE):  Primary #  Secondary #

**Confidentiality Notice:** This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy, or distribute.

