Provider Information: **FAX SENT DATE:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**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 the Oregon Tobacco Quit Line contact me to help me with my quit plan.

*(Initial)*

\_\_\_\_\_ I DO NOT give my permission to the Oregon Tobacco Quit Line 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:** \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

The Oregon Tobacco Quit Line will call you. Please check the BEST 3-hour time frame for them to reach you. ***NOTE: The Quit Line 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 #**