PA Free Quitline
FAX REFERRAL FORM
Fax to: 1-800-261-6259

pennsylvania
DEPARTMENT OF HEALTH

Today's Date _____

Fax referral to the PA Free Quitline is for individuals who are ***ready to quit in the next 30 days AND ready to accept a call from the PA Free Quitline.*** *If neither of these conditions is met, provide individual with Quitline or other tobacco cessation resource information.*

REFERRAL SOURCE: Complete this section. (Please print clearly.)

Organization Name _____ Contact Name _____

Type of Organization Select from List _____ E-mail _____

Address _____ Phone _____

City/State/Zip _____ Fax _____

The PA Free Quitline is an entity that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The PA Free Quitline will only be able to share service outcome information with you if you verify that your organization is a HIPAA-covered entity and that the use of information is for treatment purposes as permitted by HIPAA.

Please indicate whether you are a HIPAA-covered entity: I am a HIPAA-Covered Entity ☐ Yes ☐ No

☐ In the absence of the individual being physically present to provide a signature, please check to indicate that **individual has provided verbal consent** to be referred to the PA FREE Quitline.

PARTICIPANT: Complete this section. (Please print clearly.)

_____ *Initial* Yes, I am ready to quit and ask that a PA Free Quitline coach call me. I understand that the PA Free Quitline may inform the referral source about my participation. I also give permission to the PA Free Quitline to share my information with the Pennsylvania Department of Health. This information will be kept private and confidential by the Pennsylvania Department of Health.

Best times to call? (Please check all that apply.) ☐ Morning (8-12) ☐ Afternoon (12-5) ☐ Evening (5-9) ☐ Anytime

[Caller ID will display 1-800-784-8669 (Quit-Now).] ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Weekend ☐ Any day

May we leave a message? ☐ Yes ☐ No

Are you hearing impaired and need assistance? ☐ Yes ☐ No

Date of Birth / / Gender ☐ M ☐ F

Participant Name (Last) _____ (First) _____

Address _____ City _____ State _____

Zip Code _____ E-mail _____

Phone #1 ( ) - Phone #2 ( ) -

Language ☐ English ☐ Spanish ☐ Other _____

Participant Signature _____ Date _____

PLEASE FAX COMPLETED FORM TO: 1-800-261-6259

Or mail to: PA FREE Quitline, c/o National Jewish Health®, 1400 Jackson St., S117A, Denver, CO 80206