

Patient ID# \_\_\_\_\_



1-800-QUIT NOW  
Indiana's Tobacco Quitline

**Indiana Tobacco Quitline**  
TELEPHONE CONSENT FORM  
**FAX 1.800.483.3114**

# Telephone

Date Fax Sent \_\_\_\_/\_\_\_\_/\_\_\_\_

## PROVIDER INFORMATION

Clinic Name MDwise/MCO

Health Care Provider \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

I am HIPAA-Covered Entity (check one)  Yes  No  I Don't Know

Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ email \_\_\_\_\_

Comments \_\_\_\_\_

## PATIENT INFORMATION

**Gender**  Male  Female **Pregnant?**  Yes  No

Patient Name \_\_\_\_\_ Are you 18 or older?  Yes  No

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Primary Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **TYPE**  Home  Work  Cell  Other

Secondary Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **TYPE**  Home  Work  Cell  Other

Language Preference (check one)  English  Spanish  Other \_\_\_\_\_

Tobacco Type (check all that apply)  Cigarettes  Smokeless Tobacco  Cigar  Pipe

\_\_\_\_\_ I am ready to quit tobacco and request the Indiana Tobacco Quitline contact me to help me with my quit plan.  
(consent via phone)

\_\_\_\_\_ I **do not** give my permission to the Indiana Tobacco Quitline to leave a message when contacting me.  
(consent via phone)

**Consent obtained by** \_\_\_\_\_

The Indiana Tobacco Quitline 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 the selected 3-hour time frame.

6am-9am  9am-12pm  12pm-3pm  3pm-6pm  6pm-9pm

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