



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

By participating in this program I understand that outcome information may be shared with my provider for purposes of my treatment.

____ I am ready to quit tobacco and request the New Mexico Free Tobacco Helpline contact me to help me with my quit plan.
(Initial)

____ I **DO NOT** give my permission to the New Mexico Free Tobacco Helpline 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 New Mexico Free Tobacco Helpline 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 #

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