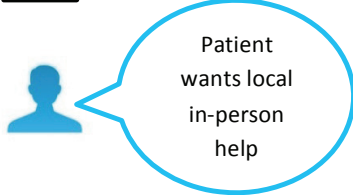


Tobacco Free Florida's Provider Fax Referral Form

 **CHECK ONE OF THE BOXES BELOW**

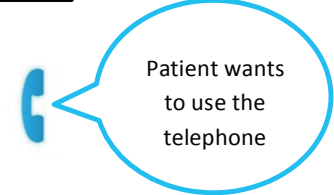
In-Person



Online



Telephone



Please Print Information Provided Below

Provider Section

Referring Provider: _____ Organization Name: _____
Department Name: _____ Main Contact Person: _____
Email: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: Florida Zip: _____
Fax Submitted by: _____ and Contact Number: _____

The Florida Quitline is an entity that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). The Florida 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 % Y % N

Patient Section

Patient First name: _____ Patient Last name: _____
Address: _____ City: _____ State: Florida Zip: _____
Email: _____ DOB: _____ Gender: _____
Best Telephone Number: _____ Alternate Telephone Number: _____

Please contact me during: Morning: 8am – Noon Afternoon: Noon – 5pm Evening: 5 – 9pm

Can we leave a voicemail? Yes No

Do you give permission for your participation details to be sent to your provider?

Yes, I give my consent No, I do not give my consent

My signature gives permission for my provider to send this form to a Tobacco Free Florida representative. I understand that I will be contacted within the next week.

Patient Signature: _____ Date: _____

Submission Instructions

If **In-Person** is checked, fax this form to **1-888-975-1534**

or email it to ahectobacco@health.usf.edu

If **Online** or **Telephone** is checked, fax this form to **1-866-688-7577**

or email it to supportservices@alere.com

