Please complete, print and submit. Reset Form

North Dakota Tobacco QUITLINE 1·800·QUIT·NOW

NORTH DAKOTA DEPARTMENT of HEALTH

Authorization to Release Information

Provider Information: **Date:___/___/_____**

Clinic Name: _____

Health Care Provider Name: _____

City: _____ **State:** _____ **Zip Code:** _____

Contact Name: _____

Fax Number: (____) _____ - _____ **Phone Number:** (____) _____ - _____

Comments:_____

Patient Information:

Client Name:_____ **DOB:___/___/_____**

Address:_____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Phone Number: (____) _____ - _____ **Alternate Phone Number:** (____) _____ - _____

I, _____, hereby authorize my physician and clinic or hospital to release the information provided in this form to the North Dakota Tobacco Quitline so I may be contacted at home regarding tobacco cessation. I also authorize North Dakota Tobacco Quitline to release information back to my physician to identify the status of my enrollment.

I understand that:

- This information will be treated professionally and confidentially in accordance with federal and state regulations.
- This consent is subject to written revocation at any time except to the extent that action has already been taken upon this consent.
- This consent will automatically expire six months from the date of the signature below.
- North Dakota Tobacco Quitline services will not be provided, as indicated on this form, without signatures on this form and a copy provided to the North Dakota Tobacco Quitline.
- My provider will not base treatment, payment, enrollment or benefits eligibility on my signing this form.
- Information disclosed pursuant to this form may be subject to re-disclosure by the recipient and the information may no longer be protected under the privacy regulations.

_____Signature Required_____	___/___/_____	_____Signature Required_____
Patient Signature	**Date**	**Witness Signature**

The North Dakota Tobacco Quitline will call you. Please indicate the best times and days for them to reach you.

7 a.m. to 11 a.m. 11 a.m. to 2 p.m. 2 p.m. to 5 p.m. 5 p.m. to 8 p.m.

Monday Tuesday Wednesday Thursday Friday Saturday

Please FAX to:
North Dakota Tobacco Quitline
Attn: Intake Assistant
(507) 293-3295

This faxed information is intended only for the use of the individual or entity to which it is addressed and contains information that is confidential. Furthermore, this information may be protected by Federal law relating to confidentiality (42 CFR Part 2) prohibiting further disclosure. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to the provider listed above via mail. Thank you.

MC5535-18rev0309

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