

OTPF GRANTEE ID: 07-3-026  
(IF AVAILABLE)

<b>REFERRING PROVIDER</b> USE STAMP, LABEL OR WRITE IN INFORMATION BELOW.  NAME _____ CLINIC/FACILITY _____ ADDRESS _____ CITY/STATE/ZIP _____ PHONE _____ FAX* _____  *REQUIRED IN ORDER TO RECEIVE CONFIRMATION OF REFERRAL.
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<b>PARTICIPANT INFORMATION</b> NAME: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ PREFERRED PHONE: _____ BEST TIME AND DAY TO CALL: _____ DO YOU NEED TTY? YES <input type="checkbox"/> NO <input type="checkbox"/> DATE OF BIRTH: _____ MAY WE LEAVE A MESSAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>
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**NOTE: PARTICIPANT SIGNATURE REQUIRED ON BOTTOM PORTION IN ORDER TO PLACE AN INITIAL PHONE CALL TO THE PARTICIPANT.**

<b>THIS PATIENT MAY USE NICOTINE REPLACEMENT THERAPY.</b>	
_____ PROVIDER SIGNATURE	_____ DATE

**CONSENT FOR RELEASE OF INFORMATION**

I, (PARTICIPANT NAME) \_\_\_\_\_, GIVE PERMISSION TO MY HEALTHCARE PROVIDER, THE OHIO TOBACCO USE PREVENTION AND CONTROL FOUNDATION OR ITS CONTRACTORS, TO RELEASE INFORMATION ABOUT MY INTEREST AND PARTICIPATION IN THE OHIO TOBACCO QUIT LINE PROGRAM TO AND FROM NATIONAL JEWISH MEDICAL AND RESEARCH CENTER (CONTRACTOR FOR THE OHIO TOBACCO QUIT LINE CALL CENTER).

THE PURPOSE OF THIS RELEASE IS TO REQUEST THAT NATIONAL JEWISH MEDICAL AND RESEARCH CENTER MAKE AN INITIAL PHONE CALL TO ME TO DISCUSS PARTICIPATION IN THE OHIO TOBACCO QUIT LINE STOP TOBACCO USE PROGRAM.

<b>REQUIRED</b>	
_____ SIGNATURE OF PARTICIPANT	_____ DATE

PLEASE FAX THIS FORM TO:  
**QUIT LINE REFERRAL SPECIALIST**  
**800-261-6259**

FOR QUESTIONS, PLEASE CONTACT:  
**1-800-QUIT NOW**  
800-784-8669