Plan First/Medicaid Tobacco Cessation Program
Patient Referral/Consent Form For Alabama Quitline

PATIENT INFORMATION

Patient's Name:		
Medicaid Number:	Date:	
Telephone:	Best Contact Time:	Day ❑ Evening ❑

I hereby authorize my healthcare provider to release my contact information and information regarding my tobacco use to the Alabama Tobacco Quitline. This authorization is continuing. I understand that the Alabama Tobacco Quitline will contact me to provide information, offer support in quitting tobacco and will provide progress reports to my healthcare provider. I agree to take part in this program and I understand that my participation is voluntary. I understand that any information I provide will be kept confidential.

Patient/Client Signature for Consent:

Comments:

HEALTHCARE PROVIDER

I request that the Alabama Tobacco Quitline, operated by Information and Quality Healthcare, contact my patient for the provision of tobacco cessation services.

Care Coordinator/Referring Provider:

Print Name:

Signature:

Facility/County Health Department Name:

Address:

Telephone:	Fax:	Date:

QUITLINE

1.800.QUITNOW

QUITNOWALABAMA.COM

1-800-784-8669

Fax to Alabama Tobacco Quitline: 1-800-692-9023

For additional forms PLEASE COPY or visit http://www.adph.org/planfirst

*Quitline office hours: 7 days a week 6am-midnight

April 1, 2017