Health Plan of Nevada
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United Healthcare
Health Plan of Nevada
Medicaid

Tobacco Cessation Program (TCP) Release of Information and Program Expectations

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Provider Name: _____ _____
Name of Facility, Provider or Person Phone Number

_____
Address City State Zip Code

To assist with my tobacco cessation treatment and obtain medication, I authorize the disclosure of the TCP records to my primay care provider. The information released will include my medical history, diagnosis and information involving tobacco cessation medication.

TCP Program Expectations

- Participate in an initial evaluation with a TCP educator. We suggest attending at least 10 of 12 group or individual behavioral modification sessions. Renew Program participants will attend four weekly sessions then participate in individual sessions or in TCP group for the remaining weeks 6-8 weeks.
- To obtain tobacco cessation medication, I understand I must attend **10 of 12 sessions** and inform the group leader at least one week **before** I need a prescription refill.
- I have read the Acknowledgement of TCP Medication Side Effects form. If I have further questions about these medications I will ask the TCP educator, my provider, or my pharmacist.
- If using tobacco cessation medication, I am to report any side effects to my Primary Care Provider (PCP) and health educator/counselor.
- With the assistance of the health educator, I will develop an abstinence plan including relapse prevention.
- To assist with my tobacco cessation treatment and obtain medication, I authorize the disclosure of the TCP records to my Primary Care Provider.

I understand my records are protected under State Confidentiality Statutes and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided. I also understand that I may revoke this consent in writing at any time.

I further acknowledge that the information to be released was fully explained to me and my consent is given of my own free will. I have read and understand the information provided in this document. As a member in the Tobacco Cessation Program, I voluntarily agree to participate in the program and follow expected guidelines.

Please type your name below which will serve as your signature of consent and return as directed in your initial email. If you are unable to return via email, please let your counselor know so she can make other arrangements, or you may call **702-243-4605**.

Member Signature _____ Date _____
Print Name

This release expires 30 days from termination of treatment