**Provider Information:**

<table>
<thead>
<tr>
<th>CLINIC NAME</th>
<th>CLINIC ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UConn Health West Hartford</td>
<td>06119</td>
</tr>
</tbody>
</table>

**HEALTH CARE PROVIDER**

Dr. Elizabeth Appel

**CONTACT NAME**

Dr. Elizabeth Appel

**FAX NUMBER**

(860) 523-3775

**PHONE NUMBER**

(860) 679-7692

**I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE)**

- [X] YES
- [ ] NO
- [ ] DON'T KNOW

---

**Patient Information:**

**PATIENT NAME**


**DATE OF BIRTH**


**GENDER**

- [ ] MALE
- [ ] FEMALE

**ADDRESS**


**CITY**


**ZIP CODE**


**PRIMARY PHONE NUMBER**


**SECONDARY PHONE NUMBER**


**LANGUAGE PREFERENCE (PLEASE CHECK ONE)**

- [ ] ENGLISH
- [ ] SPANISH
- [ ] OTHER

---

I am ready to quit tobacco and request the Connecticut Quitline contact me to help me with my quit plan.

(Initial)

I DO NOT give my permission to the Connecticut Quitline to leave a message when contacting me.

(Initial)

** By not initialing, you are giving your permission for the quitline to leave a message.**

**PATIENT SIGNATURE: ______________________________ DATE: _____/_____/_____**

The Connecticut Quitline will call you. Please check the BEST 3-hour time frame for them to reach you. **NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.**

- [ ] 6AM – 9AM
- [ ] 9AM – 12PM
- [ ] 12PM – 3PM
- [ ] 3PM – 6PM
- [ ] 6PM – 9PM

**WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (CHECK ONE):**

- [ ] Primary #
- [ ] Secondary #