



KICK THE NIC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME: _____

WIN: _____
Please print

ADDRESS: _____

DATE OF BIRTH: _____ TELEPHONE _____
NUMBER: _____

I hereby authorize the release of my Tobacco Free Verification Form:

To: Business Services

This authorization is valid until the Quit Date of: _____

Patient: _____ Date: _____

Signature