Referral Authorization

Down Syndrome Association of Central Ohio
510 E. North Broadway
Columbus, OH 43214
Ph. 614-263-6020
Fax 614-263-6094

Please Print

Child's Name:______________________________ Parent/Guardian:_______________________________

DOB: _____________________________________ Date of Referral:________________________________

Address:____ City:_________________ Ohio zip:______

County:______________________ Phone #_____________________ E-mail:______________________

Diagnosis:____

Doctor/Person Making Referral:____

Birth Hospital: ____

Consent for Release of Information

I, ___________________________, as parent or guardian of minor child _______________________________________ give ____________________________________consent to make a referral and to release the information listed above to the Down Syndrome Association of Central Ohio and to contact me to coordinate services. I also give consent for the Down Syndrome Association of Central Ohio to exchange information with ___________________________________ for the purpose of insuring continued and appropriate care for my child. This consent for referral and exchange of information expires one year from the date signed unless revoked by me prior to that time.

____ ___________________________
Signature of person authorized to consent Date Signed

____ ___________________________
Signature of Witness Date Signed

☐ I WOULD like someone from the Down Syndrome Association of Central Ohio to contact me by phone about my child with Down syndrome.

☐ I WOULD NOT like to be contacted by phone, but instead mailed materials about services.