DSACK Referral Authorization Form

Down Syndrome Association of Central Kentucky ~ 1050 Chinoe Road, Suite 204 ~
Lexington, KY 40502 ~ 859-494-7809 ~ www.dsack.org ~ dsack.org@gmail.com

Please print

Child's Name: ____ **Date of Referral:** ___________________________

Age: _________________ **Gender:** __________ **Hospital:** ____

Parent/Guardian Name: ______________________________________ **Parent Phone:** ____________________________

Parent Email Address: ____

Parent Address: ____

City: ____ **Zip:** ____

Person Making Referral: ____

Title of Peron Making Referral: ____

Email address of Person Making Referral: ____

Phone number of Person Making Referral:____

Consent for Release of Information to DSACK

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 Kentucky (DSACK). I also give consent for DSACK to contact me to offer information about DSACK's programs, services and resources available.

Printed Name of person authorized to give consent: ____

Relationship of person authorized to give consent: ____

Signature of person authorized to give consent: ____________________________________Date signed: _____________

Please indicate your preferences on DSACK's communication with you:

- € I WOULD like someone from DSACK to contact me **by phone** about programs, services, and resources available for my child with Down syndrome.
- € I WOULD like someone from DSACK to contact me **by email** about programs, services, and resources available for my child with Down syndrome.
- € I WOULD like to be **added to DSACK's email communication list**.
- € I WOULD like to be **added to DSACK's mailing list** to receive the quarterly magazine.
- € I WOULD like to be connected with a **Mentor Family** from DSACK.