



## Release of Information AUTHORIZATION FORM

To: Down Syndrome Association for Families of Nebraska  
PO Box 57362 Lincoln, NE 68505  
402-770-9826  
medicaloutreach@dsafnebraska.org

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ and its affiliates, its employees and agents to release to the Down Syndrome Association for Families of Nebraska (DSAF) my personal contact information which identifies my name, email address, hospital room number, and phone number for the purpose of helping me connect to community resources and supports related to Down syndrome. This authorization is valid from the date of my signature below and shall expire in 6 months from the date of signature.

I understand that I have a right to revoke this authorization by providing written notice to \_\_\_\_\_. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Name: \_\_\_\_\_

Patient/Child: \_\_\_\_\_

Patient/Child D.O.B \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Referring Physician \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_