



708 E. Michigan Street
Indianapolis, IN 46202
317.925.7617
317.925.7619 (f)
www.dsindiana.org

Release of Information Authorization

Please fax completed form to 317.925.7619

Patient Name: _____ DOB: _____

Home Phone: _____ Cell/Work Phone: _____

Address: _____

City/State/Zip: _____

Email: _____

A) I hereby authorize records FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

B) To be released TO:

Name: Down Syndrome Indiana

Address: 708 E. Michigan Street

City/State/Zip: Indianapolis, IN 46202

Phone: 317-925-7617

Fax: 317-925-7619

C) The following information may be released:

Name of child with Down syndrome: _____

Child's gender: _____ Child's Birth Date: _____

Hospital: _____ Room #/Code: _____

Father's Name: _____

Mother's Name: _____

I would welcome a phone call from Down Syndrome Indiana YES NO

I would welcome a visit from Down Syndrome Indiana YES NO

Please include our family on Down Syndrome Indiana's mailing list YES NO

Primary Language: English Spanish Other: _____

Signature: _____ Date: _____