**MDSC Prenatal Parents First Call program** offers expectant families accurate, up-to-date information as well as the opportunity to connect with a parent who also received the diagnosis of Down syndrome prenatally. These parents are available 24/7 to listen, answer questions, and provide accurate information.

Due to privacy concerns, the hospital or medical professional cannot share your information with MDSC without your permission. If you would like to connect with us, please complete the following information:

**I grant permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Hospital or Medical Professional) to release my name, address, phone number and baby’s name and date of birth to the Massachusetts Down Syndrome Congress (MDSC) so that I may be contacted and authorize such contact by the MDSC.**

**I hereby release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Hospital or Medical Professional), MDSC and their employees from any and all liability for any and all such claims or damages which may at any time result on account of compliance with this authorization. I also acknowledge that I am the parent or legal guardian of this baby.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (street, city/town, state, zip):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I hereby release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Hospital or Medical Professional), MDSC and their employees from any and all liability for any and all such claims or damages which may at any time result on account of compliance with this authorization.

I am requesting (please check all that apply):

□ Accurate, up-to-date written information about Down syndrome

□ A phone call within 24 hours of receipt of this form from an MDSC Prenatal parent mentor

□ An email within 24 hours of receipt of this form from an MDSC Prenatal parent mentor

**Please FAX this form to: (781) 221-0011 (MDSC) or email to FIRSTCALL@MDSC.ORG**