MISSOURI FAMILY TO FAMILY RESOURCE CENTER
UMKC INSTITUTE FOR HUMAN DEVELOPMENT | UCEDD

DDD Regional Office
Release of Information and Referral Form

I hereby authorize the _____ Regional Office (RO) to provide my contact information to: *Missouri Family to Family Resource Center.*

I understand that a representative from Missouri Family to Family will contact me and offer individualized information, problem solving resources, emotional and peer-mentoring support. This is a free service available to all Missouri Residents.

Content to be released: *Contact information*
For the Purpose of: *Information and peer support*

This release will remain in effect for one year from the date listed below unless otherwise directed by customer / guardian.

_____ _____
Signature of customer/guardian Date

First Name: _____Last Name: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____ County:_____

Home phone: _____Work Phone:_____ Cell Phone: _____

Best Time to Contact: morning afternoon evening

E-mail: _____

☐ **Requesting Mentor** ☐ **Wants to be a Mentor**

Please Provide a Brief Statement of Need
(immediate concerns, age of child, diagnosis, etc.):

Referring Service Coordinator: _____**Phone Number**_____

When completed please submit electronically or fax to **(888) 503-3107.**