

## Pennsylvania Adoption Information Registry Birth Parent/Birth Parent Survivor Authorization to Release/Not Release Information and Registration Form

**Completing this form is voluntary.** However, if you are submitting a request to the Department of Health to redact your name on your birth child's noncertified copy of the original birth record, you must complete sections I, IIa or IIIa, and VI. We encourage you to provide as much information as you can. You may choose to :

1. release information that will identify you to the birth child or their family;
2. provide only non-identifying information that will not identify you; or
3. both.

Each section of this form is designated as identifying or non-identifying. Please type or print in black or blue ink. Each birth parent/birth parent survivor who reports information must complete a separate form for each child placed for adoption. If you don't know or are unsure about an answer, leave it blank.

**Identifying information** will include names and contact information.

**Non-identifying information** does not include names and contact information but does include medical, social and educational information, etc.

**Please check the appropriate choice below:**

- I am providing family information for the first time.                       I am updating family information previously submitted.

**Please indicate your relationship to the child for whom you are completing this information:**

- Birth Mother                       Birth Father                       Birth Parent Survivor\*

\*Birth Parent Survivor includes the deceased birth parent's spouse, parent, sibling, child (birth, adoptive and stepchild), grandchild, aunt, uncle, children of aunts and uncles if no other relatives survive and children of grandchildren if no other relatives survive.

### I. CHILD'S INFORMATION

<b>CHILD'S CURRENT NAME (Last, First, Middle)</b>		<b>CHILD'S NAME RECORDED ON ORIGINAL BIRTH CERTIFICATE (Last, First, Middle)</b>		
<b>DATE OF BIRTH (MM/DD/YYYY)</b>		<b>GENDER</b>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
<b>PLACE OF BIRTH</b>	<b>COUNTY</b>	<b>CITY/MUNICIPALITY</b>	<b>STATE</b>	<b>HOSPITAL (if applicable)</b>
<b>LOCATION WHERE PARENTAL RIGHTS WERE TERMINATED (City/County, State)</b>		<b>DATE PARENTAL RIGHTS WERE TERMINATED (MM/DD/YYYY)</b>		

### AUTHORIZATION TO RELEASE/NOT RELEASE IDENTIFYING INFORMATION

You may select as many or as few of the choices listed below as you wish. I agree to release **identifying** information to the individuals checked below:

- |   |  |
|---|--|
| <input type="checkbox"/> Birth child (when he or she turns 18)  | <input type="checkbox"/> Birth child's descendants (if the birth child is deceased)  |
| <input type="checkbox"/> Birth child's adoptive parents (if the birth child is under 18 or adjudicated incapacitated) | <input type="checkbox"/> Birth child's birth grandparents provided the birth child is at least 21 or I am adjudicated incapacitated or deceased. |
| <input type="checkbox"/> Birth child's legal guardian   | <input type="checkbox"/> Birth child's birth siblings if both are 21.  |

Even if you choose to release identifying information to the birth child, you may specify that you do or do not wish to have contact.

- I wish to have contact with the birth child.                       I do not wish to have contact with the birth child.
- I only wish to have contact through an intermediary/Authorized Search Representative.

I understand that by signing below, I am agreeing to the release of identifying information to only the people checked above. By not checking any of the people above, I understand that **NO** identifying information will be released. I may change this consent at any time by updating this form or by submitting a Withdrawal of Authorization to Release Information Form.

<b>SIGNATURE OF BIRTH PARENT/ BIRTH PARENT SURVIVOR</b>		<b>DATE</b>	
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# Pennsylvania Adoption Information Registry Birth Parent/Birth Parent Survivor Authorization to Release/Not Release Information and Registration Form

## REGISTRATION INFORMATION

### IIa. BIRTH MOTHER'S PERSONAL (IDENTIFYING) INFORMATION

<b>BIRTH MOTHER'S NAME (Last, First, Middle)</b>	<b>PREVIOUS NAMES (Include maiden name, nicknames, and aliases. Last, First, Middle)</b>		
<b>DATE OF BIRTH (MM/DD/YYYY)</b>	<b>(AREA CODE) DAYTIME TELEPHONE</b>		
<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>

### IIb. BIRTH MOTHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

<b>HIGHEST GRADE LEVEL ACHIEVED</b>	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
<b>I WOULD DESCRIBE MYSELF AS:</b>	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
<b>MARITAL STATUS</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>CHILDREN</b>	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	
<b>RACE/ETHNICITY (Check all that apply)</b>				
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> White	<input type="checkbox"/> Other _____	Ethnicity Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>HEIGHT</b>	<b>WEIGHT</b>	<b>EYE COLOR</b>	<b>HAIR COLOR</b>	<b>HAIR TYPE</b>
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight
<b>COMPLEXION</b>			<b>HANDEDNESS</b>	
<input type="checkbox"/> Light	<input type="checkbox"/> Olive	<input type="checkbox"/> Medium	<input type="checkbox"/> Dark	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed

### IIc. BIRTH MOTHER'S OTHER CHILDREN - (IDENTIFYING) Use Additional Page if Needed

<b>PLACED FOR ADOPTION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>NAME</b>		<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DATE OF BIRTH</b>	
<b>CITY, STATE</b>		<b>FATHER'S NAME</b>			
<b>PLACED FOR ADOPTION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>NAME</b>		<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DATE OF BIRTH</b>	
<b>CITY, STATE</b>		<b>FATHER'S NAME</b>			
<b>PLACED FOR ADOPTION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>NAME</b>		<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DATE OF BIRTH</b>	
<b>CITY, STATE</b>		<b>FATHER'S NAME</b>			
<b>PLACED FOR ADOPTION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>NAME</b>		<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DATE OF BIRTH</b>	
<b>CITY, STATE</b>		<b>FATHER'S NAME</b>			
<b>PLACED FOR ADOPTION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>NAME</b>		<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DATE OF BIRTH</b>	
<b>CITY, STATE</b>		<b>FATHER'S NAME</b>			

# Pennsylvania Adoption Information Registry Birth Parent/Birth Parent Survivor Authorization to Release/Not Release Information and Registration Form

### IIIa. BIRTH FATHER'S PERSONAL (IDENTIFYING) INFORMATION

BIRTH FATHER'S NAME (Last, First, Middle)		PREVIOUS NAMES (Include nicknames and aliases. Last, First, Middle)		
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE		
STREET ADDRESS		CITY	STATE	ZIP CODE

### IIIb. BIRTH FATHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

HIGHEST GRADE LEVEL ACHIEVED	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
I WOULD DESCRIBE MYSELF AS:	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
MARITAL STATUS	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
CHILDREN	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	
RACE/ETHNICITY (Check all that apply)				
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____            Ethnicity Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No				
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	HAIR TYPE
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight
COMPLEXION			HANDEDNESS	
<input type="checkbox"/> Light <input type="checkbox"/> Olive <input type="checkbox"/> Medium <input type="checkbox"/> Dark			<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed	

### IIIc. BIRTH FATHER'S OTHER CHILDREN - (IDENTIFYING) Use Additional Page if Needed

PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	
CITY, STATE		MOTHER'S NAME			
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	
CITY, STATE		MOTHER'S NAME			
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	
CITY, STATE		MOTHER'S NAME			
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	
CITY, STATE		MOTHER'S NAME			
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	
CITY, STATE		MOTHER'S NAME			

## Pennsylvania Adoption Information Registry Birth Parent/Birth Parent Survivor Authorization to Release/Not Release Information and Registration Form

### IV. BIRTH PARENT SURVIVOR'S (IDENTIFYING) INFORMATION

<b>NAME (Last, First, Middle)</b>			
<b>DATE OF BIRTH (MM/DD/YYYY)</b>		<b>(AREA CODE) DAYTIME TELEPHONE</b>	
<b>STREET ADDRESS</b>		<b>CITY</b>	<b>STATE</b>
<b>ZIP CODE</b>			

### V. PREGNANCY, BIRTH AND EARLY CHILDHOOD HISTORY (BIRTH MOTHER ONLY - NON-IDENTIFYING)

<b>AGE AT FIRST MENSTRUAL PERIOD</b>	<b>IF APPLICABLE, AGE AT MENOPAUSE</b>	<b>NUMBER OF PREGNANCIES</b>
<b>NUMBER OF LIVE BIRTHS</b>	<b>NUMBER OF MISCARRIAGES</b>	<b>MULTIPLE BIRTHS</b>
		<input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other: _____
<b>HISTORY OF REPRODUCTIVE SYSTEM PROBLEMS</b>		
<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, check all that apply below)		
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Fibroid Tumors (Benign)
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Other _____	<input type="checkbox"/> Ovarian Cysts (Benign)

#### THE QUESTIONS BELOW PERTAIN SPECIFICALLY TO THE PREGNANCY FOR THE CHILD IDENTIFIED IN SECTION I.

<b>COMPLICATIONS DURING THIS PREGNANCY</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, check all that apply below)	
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Toxemia	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Gestational Diabetes
		<input type="checkbox"/> Other _____	
<b>ANY INJURY DURING PREGNANCY?</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below.)	
<b>X-RAY PROCEDURES DURING PREGNANCY?</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Month of Pregnancy _____ )	
If YES, purpose of X-Ray:			
<b>DISEASES DURING PREGNANCY?</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, list below.)	
<b>DISEASE</b>	<b>TREATMENT</b>		
<b>LENGTH OF PREGNANCY?</b>		<input type="checkbox"/> Premature - Number of weeks early: _____ <input type="checkbox"/> Full-Term <input type="checkbox"/> Post-Term - Number of weeks late: _____	
<b>TOBACCO USE DURING PREGNANCY?</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of cigarettes daily: _____ )	
<b>ALCOHOL USE DURING PREGNANCY?</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of drinks weekly: _____ )	
<b>LIST OVER-THE-COUNTER, PRESCRIPTION, LEGAL AND ILLEGAL DRUGS TAKEN DURING PREGNANCY</b>			
<b>DURATION OF LABOR</b>		<b>TYPE OF DELIVERY</b>	
Hours: _____	<input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Breech <input type="checkbox"/> Caesarean		
<b>COMPLICATIONS DURING DELIVERY?</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below)	

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### VI. FAMILY MEDICAL HISTORY (NON-IDENTIFYING)

This section applies only to the birth family member who is completing this form and his or her blood relatives.

- Check SELF if medical condition applies to the BIRTH PARENT who is completing the form.
- Check FAMILY if medical condition applies to a blood relative of the birth parent.
  - When FAMILY is checked, complete the RELATIONSHIP TO BIRTH PARENT column.
  - Indicate if family member is a maternal (birth parent's mother's side) or a paternal (birth parent's father's side) relative.

MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT	MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT
<b>ALLERGIES</b>							
ENVIRONMENTAL				FOOD			
PLANT				DRUG/CHEMICAL			
ANIMAL							
OTHER (specify):							
<b>EAR &amp; EYE CONDITIONS</b>							
CATARACTS				FAR-SIGHTED			
GLAUCOMA				ASTIGMATISM			
COLOR BLINDNESS							
BLINDNESS				Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			Type: <input type="checkbox"/> Partial <input type="checkbox"/> Total
DEAFNESS				Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			Type: <input type="checkbox"/> Partial <input type="checkbox"/> Total
OTHER (specify):							
<b>BLOOD, HEART &amp; CIRCULATORY CONDITIONS</b>							
HEART ATTACK				HIGH BLOOD PRESSURE			
STROKE				ANEMIA			
HARDENING OF THE ARTERIES				HEMOPHILIA			
BLOOD CLOTS IN THE LEGS				SICKLE CELL ANEMIA			
OTHER (specify):							
<b>BRAIN &amp; NERVOUS SYSTEM CONDITIONS</b>							
ALZHEIMER'S DISEASE				PARKINSON'S DISEASE			
MULTIPLE SCLEROSIS				MIGRAINE HEADACHES			
EPILEPSY & OTHER SEIZURE OR CONVULSIVE CONDITIONS				HUNTINGTON'S DISEASE			
CEREBRAL PALSY				TOURETTE'S SYNDROME			
OTHER (specify):							

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MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT	MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO BIRTH PARENT
<b>HORMONAL DISORDERS</b>							
DIABETES							
THYROID DISORDER			Specify: <input type="checkbox"/> Overactive thyroid <input type="checkbox"/> Underactive thyroid <input type="checkbox"/> Goiter <input type="checkbox"/> Iodine Deficiency				
PITUITARY GLAND DISORDER			Specify: <input type="checkbox"/> Excessive hormone <input type="checkbox"/> Reduced hormone <input type="checkbox"/> Growth hormone deficiency				
OTHER (specify):							
<b>INTELLECTUAL &amp; DEVELOPMENTAL CONDITIONS</b>							
DOWN SYNDROME							
PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM							
INTELLECTUAL DISABILITY			Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary				
SPEECH/COMMUNICATION DISORDERS			Cause: <input type="checkbox"/> Brain damage <input type="checkbox"/> Developmental delay <input type="checkbox"/> Structural abnormality (mouth)				
LEARNING DISORDERS			Specify: <input type="checkbox"/> Dyslexia (reading) <input type="checkbox"/> Dysgraphia (writing) <input type="checkbox"/> Minimal brain damage				
OTHER (specify):							
<b>MENTAL &amp; BEHAVIORAL CONDITIONS</b>							
SCHIZOPHRENIA				ATTENTION DEFICIT DISORDER (ADD)			
ANXIETY DISORDER				ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)			
MAJOR DEPRESSIVE DISORDER				DRUG ABUSE			
BIPOLAR DISORDER (MANIC DEPRESSIVE)				POST-TRAUMATIC STRESS DISORDER			
ALCOHOLISM				ANOREXIA NERVOSA			
OBSESSIVE COMPULSIVE DISORDER							
OTHER (specify):							
<b>GASTROINTESTINAL URINARY SYSTEM CONDITIONS</b>							
KIDNEY DISEASE			Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary				
LIVER DYSFUNCTION			Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary				
GALL BLADDER DISORDER			<input type="checkbox"/> Gall stones <input type="checkbox"/> Infection <input type="checkbox"/> Tumor				
ULCERS							
DIVERTICULITIS							
ULCERATIVE COLITIS/CROHN'S DISEASE							
OTHER (specify):							

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MEDICAL CONDITION (check all that apply)	S	E	L	F	A	M	I	L	Y	RELATIONSHIP TO BIRTH PARENT	MEDICAL CONDITION (check all that apply)	S	E	L	F	A	M	I	L	Y	RELATIONSHIP TO BIRTH PARENT	
<b>CANCER</b>																						
BLOOD (Leukemia)											BRAIN											
COLON											HODGKIN'S DISEASE											
PROSTATE											PANCREAS											
UTERINE											LIVER											
BREAST											OVARIAN											
LUNG											CERVICAL											
SKIN											STOMACH											
BONE											THROAT											
OTHER (specify):																						
<b>GENETIC CONDITIONS</b>																						
MUSCULAR DYSTROPHY											MARFAN'S SYNDROME											
SPINA BIFIDA											TAY-SACHS DISEASE											
CLUB FOOT											HARE LIP											
DWARFISM											CLEFT PALATE											
CYSTIC FIBROSIS																						
OTHER (specify):																						
<b>OTHER CONDITIONS</b>																						
HIGH CHOLESTEROL											OBESITY											
ARTHRITIS											LUPUS											
ASTHMA																						
EXPOSURE TO CHEMICALS & TOXIC MATERIALS (specify):																						
OTHER (specify):																						

I certify that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (section 9404 of the Pennsylvania Crimes Code). Further, I understand that it is my responsibility to notify the registry of any change in my address or submitted information.

<b>SIGNATURE</b>		<b>DATE</b>	
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IN RE: : IN THE COURT OF COMMON PLEAS  
ADOPTION OF : DAUPHIN COUNTY, PENNSYLVANIA  
\_\_\_\_\_ : ORPHANS' COURT DIVISION  
: :  
\_\_\_\_\_ : NO.: \_\_\_\_\_

**WAIVER OF CONFIDENTIALITY**

I, \_\_\_\_\_, residing at \_\_\_\_\_  
\_\_\_\_\_, am the biological parent of  
\_\_\_\_\_, born on \_\_\_\_\_, at  
\_\_\_\_\_.

(Hospital Name, Street Address, City, County, State)

I hereby authorize the Dauphin County Orphans' Court to release my identifying information upon request of the adoptee if eighteen (18) years of age or older, or, if less than eighteen (18) years of age, to the adoptive parent or legal guardian.

\_\_\_\_\_  
Signature of Biological Parent

Sworn (or affirmed) before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by the person whose signature appears above and whose identity is either personally known to me or satisfactorily proven to me.

\_\_\_\_\_  
Signature of Official Administering Oath