

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

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

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.

SIGNATURE OF BIRTH PARENT/ BIRTH PARENT SURVIVOR		DATE	
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REGISTRATION INFORMATION

IIa. BIRTH MOTHER'S PERSONAL (IDENTIFYING) INFORMATION

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

IIb. BIRTH MOTHER'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

IIc. BIRTH MOTHER'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	FATHER'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	FATHER'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	FATHER'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	FATHER'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	FATHER'S NAME		

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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		

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IV. BIRTH PARENT SURVIVOR'S (IDENTIFYING) INFORMATION

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

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

AGE AT FIRST MENSTRUAL PERIOD	IF APPLICABLE, AGE AT MENOPAUSE	NUMBER OF PREGNANCIES
NUMBER OF LIVE BIRTHS	NUMBER OF MISCARRIAGES	MULTIPLE BIRTHS
		<input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other: _____
HISTORY OF REPRODUCTIVE SYSTEM PROBLEMS		
<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.

COMPLICATIONS DURING THIS PREGNANCY		<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 _____	
ANY INJURY DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below.)	
X-RAY PROCEDURES DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Month of Pregnancy _____)	
If YES, purpose of X-Ray:			
DISEASES DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, list below.)	
DISEASE	TREATMENT		
LENGTH OF PREGNANCY?		<input type="checkbox"/> Premature - Number of weeks early: _____ <input type="checkbox"/> Full-Term <input type="checkbox"/> Post-Term - Number of weeks late: _____	
TOBACCO USE DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of cigarettes daily: _____)	
ALCOHOL USE DURING PREGNANCY?		<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of drinks weekly: _____)	
LIST OVER-THE-COUNTER, PRESCRIPTION, LEGAL AND ILLEGAL DRUGS TAKEN DURING PREGNANCY			
DURATION OF LABOR	Hours: _____	TYPE OF DELIVERY	<input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Breech <input type="checkbox"/> Caesarean
COMPLICATIONS DURING DELIVERY?		<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
ALLERGIES							
ENVIRONMENTAL				FOOD			
PLANT				DRUG/CHEMICAL			
ANIMAL							
OTHER (specify):							
EAR & EYE CONDITIONS							
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):							
BLOOD, HEART & CIRCULATORY CONDITIONS							
HEART ATTACK				HIGH BLOOD PRESSURE			
STROKE				ANEMIA			
HARDENING OF THE ARTERIES				HEMOPHILIA			
BLOOD CLOTS IN THE LEGS				SICKLE CELL ANEMIA			
OTHER (specify):							
BRAIN & NERVOUS SYSTEM CONDITIONS							
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
HORMONAL DISORDERS							
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):							
INTELLECTUAL & DEVELOPMENTAL CONDITIONS							
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):							
MENTAL & BEHAVIORAL CONDITIONS							
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):							
GASTROINTESTINAL URINARY SYSTEM CONDITIONS							
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
CANCER																					
BLOOD (Leukemia)											BRAIN										
COLON											HODGKIN'S DISEASE										
PROSTATE											PANCREAS										
UTERINE											LIVER										
BREAST											OVARIAN										
LUNG											CERVICAL										
SKIN											STOMACH										
BONE											THROAT										
OTHER (specify):																					
GENETIC CONDITIONS																					
MUSCULAR DYSTROPHY											MARFAN'S SYNDROME										
SPINA BIFIDA											TAY-SACHS DISEASE										
CLUB FOOT											HARE LIP										
DWARFISM											CLEFT PALATE										
CYSTIC FIBROSIS																					
OTHER (specify):																					
OTHER CONDITIONS																					
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.

SIGNATURE		DATE	
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