

NAME REDACTION REQUEST FORM

Act 127 of 2016 authorizes the Department of Health to release noncertified copies of original birth records to adopted individuals or their lineal descendants. Birth parents listed on the original birth record may complete this form to request that his/her name be redacted from documents issued against the original birth record. If redacted, your name will not print on the original birth record.

TYPE OF REQUEST

I wish to redact my name from the Noncertified Copy of Original Birth Record for the adopted person listed below. I understand that my name may have already been released to the Adopted Person if the Adopted Person's application is received by the State Registrar prior to the State Registrar receiving and approving my Name Redaction Request form.

I wish to remove the Name Redaction Request Form that I previously filed with the State Registrar. I understand that my name may appear on future issuances of the Noncertified Copy of Original Birth Record for the adopted person.

INFORMATION FROM BIRTH PARENT SUBMITTING THIS REQUEST

I am the: Mother/Parent Father/Parent

Current Name _____
(First, Middle, Last)

Street Address _____ City, State Zip _____

Daytime Phone Number _____ Email Address _____

ORIGINAL BIRTH RECORD INFORMATION

Please provide complete and accurate information. Information provided must be typed or printed legibly.

CHILD'S INFORMATION

Name at Birth _____
(First, Middle, Last)

Sex Male Female Date of Birth _____ Actual Estimated

City of Birth _____ County of Birth _____ State of Birth _____

MOTHER'S/PARENT'S INFORMATION

Mother's/Parent's Name as Listed on the Original Birth Record _____
(First, Middle, Last Name Prior to 1st Marriage)

Mother's/Parent's Date of Birth (if known): _____

FATHER'S/PARENT'S INFORMATION

Father's/Parent's Information not listed on Original Birth Record

Father's/Parent's Name as Listed on the Original Birth Record _____
(First, Middle, Last Name Prior to 1st Marriage)

Father's/Parent's Date of Birth (if known): _____

ACKNOWLEDGEMENT

I understand that in order for the Department of Health to approve this request that I must complete the following:

Include two forms of identification with this request. Acceptable forms of identification include a legible photocopy of the following:

- A valid government-issued photo ID verifying your name and current mailing address. Examples include a state-issued driver’s license or a non-driver photo ID. Expired IDs cannot be accepted.
- A second form of identification such as a military or employment ID, utility bill, pay stub, insurance card, car registration or lease/ rental agreement.

Mail this form and two forms of identification to the following address:

Department of Health
 Bureau of Health Statistics & Registries
 Birth Registry
 555 Walnut Street, 6th Floor
 Harrisburg, PA 17101-1934

If I am requesting my name to be redacted, I have submitted a [Birth Parent/Birth Parent Survivor Authorization to Release Information and Registration Form](#) to the Pennsylvania Adoption Information Registry, Department of Human Services. At a minimum, I have completed Sections I, IIa or IIIa, and VI of this form.

If I have previously filed a [Birth Parent/Birth Parent Survivor Authorization to Release Information and Registration Form](#) with the Department of Human Services, I have updated the “VI. Family Medical History” section of the form within the last month.

SUBSCRIBED AND SWORN TO OR AFFIRMED BEFORE ME:

By signing this form, I am attesting that I am the birth parent of the adopted person to whom this form pertains.

Current Name _____
(First, Middle, Last)

Signature of Birth Parent _____ Subscribed and sworn to or affirmed before me: _____
(Month-Day-Year)

Signature of Notary _____

SEAL