

PLEASE RETURN COMPLETED
FORM TO:

**Adoption Medical
History Registry
DPW/OCYF
P.O. Box 2675
Harrisburg, PA 17105-2675**

For additional
Information, Call:

1-800-227-0225



EDWARD G. RENDELL
GOVERNOR

ESTELLE B. RICHMAN
SECRETARY



CY 911 - 5/03

Pennsylvania's Adoption Medical History Registry

*Sharing Important
Health Information*

Adoptee Request Form

Commonwealth of Pennsylvania
Department of Public Welfare

ADOPTION MEDICAL HISTORY REQUEST FORM

This form may be completed by an adoptee 18 years of age or older or by an adoptive parent or legal guardian of a minor child. After reaching age 18, adoptees must complete their own request.

Any birth family medical information on file will be mailed to the requestor. If no information is on file at the time of the request, a notice of that fact will be mailed.

Requests remain active with the Registry. Information received in the future will be mailed to the requestor. It is important to notify the Registry of any change of address.

REQUESTOR: ADOPTEE ADOPTIVE PARENT/GUARDIAN

NAME OF THE ADOPTEE: _____
Last First Middle Maiden

****DO NOT LIST THE NAME THAT APPEARS ON THE ORIGINAL BIRTH CERTIFICATE PRIOR TO THE ADOPTION.****

CURRENT NAME OF THE ADOPTEE
(IF DIFFERENT FROM ABOVE): _____

GENDER OF ADOPTEE: Female Male BIRTHDATE: _____
(MONTH, DAY, YEAR)

PLACE OF BIRTH: _____
(COUNTY) (CITY, BOROUGH OR TOWNSHIP) (STATE)

BIRTH CERTIFICATE STATE FILE NUMBER: _____

PLACE OF FINALIZATION: _____
(COUNTY) (CITY, BOROUGH OR TOWNSHIP) (STATE)

ADOPTIVE MOTHER'S NAME: _____
Maiden Last First M.I.

ADOPTIVE FATHER'S NAME: _____
Last First M.I.

LEGAL GUARDIAN'S NAME: _____
Last First M.I.

ADDRESS OF REQUESTOR: _____
Street Address

City State Zip

I certify that, to the best of my knowledge, this information is true and factual. Further, I understand that it is my responsibility to notify the Registry of any change in address.

SIGNATURE

DATE

You must attach a copy of a valid driver's license OR have this form notarized.

NOTARY
SEAL