



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

BIOLOGICAL PARENT REGISTRATION IDENTIFICATION FORM

Each biological parent desiring to register must file a separate form with the Division of Vital Records, P.O. Box 1528, New Castle, PA 16103.

CHILD'S PERSONAL DATA	1. NAME (First, Middle, Last)	2. SEX	3. DATE OF BIRTH (Month, Day, Year)
	4a. HOSPITAL NAME (If no hospital, give street & no.)	4b. CITY, BORO, OR TOWNSHIP OF BIRTH	4c. COUNTY OF BIRTH
	5. MOTHER'S MAIDEN NAME (First, Middle, Last)		
	6. IF KNOWN, LIST COURT, DOCKET NUMBER, COUNTY, STATE, AND DATE OF ADOPTION		

Pursuant to Act 1984-195 [23 Pa. C.S. § 2905] and 28 Pa. Code § 1.49, a biological parent voluntarily completing and filing this form with the Department of Health requests the Department to release the identifying information to the adoptee, adoptive parents, or legal guardian upon request. Information on the Certificate of Live Birth will be released only if both biological parents have completed and have on file a valid consent form.

If there is a change of address, a new form should be completed by the biological parent. At any time a biological parent(s) may revoke the release of identifying information by contacting the Department of Health and completing and filing the necessary forms.

AFFIDAVIT OF BIOLOGICAL PARENT	Being duly sworn or by solemn affirmation, I state that I am the biological parent of the above child and do hereby authorize the Department of Health to release the following 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	_____
	Current Name of Biological Parent <small>(Please Print)</small>	_____
	Complete Address <small>(Please Print)</small>	_____ _____

SEAL	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
	<i>Please use stamp or print name, municipality, county, and commission expiration date below.</i>



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WITHDRAWAL OF BIOLOGICAL PARENT CONSENT FORM

A biological parent completing this form revokes the authority of the Department of Health to release identifiable information to an adoptee, adoptive parents, or legal guardian. File form with the Division of Vital Records, P.O. Box 1528, New Castle, PA 16103. The Division of Vital Records will notify the biological parent in writing upon receipt of this form.

CHILD'S PERSONAL DATA	1. NAME (First, Middle, Last)	2. SEX	3. DATE OF BIRTH (Month, Day, Year)
	4a. HOSPITAL NAME (If no hospital, give street & no.)	4b. CITY, BORO, OR TOWNSHIP OF BIRTH	4c. COUNTY OF BIRTH
	5. MOTHER'S MAIDEN NAME (First, Middle, Last)		
	6. IF KNOWN, LIST COURT, DOCKET NUMBER, COUNTY, STATE, AND DATE OF ADOPTION		
AFFIDAVIT OF BIOLOGICAL PARENT	<p>Being duly sworn or by solemn affirmation, I state that I am the individual who completed and filed the Biological Parent Registration Identification Form for release of identifiable information to the above-referenced child. I hereby instruct the Department of Health not to release any information, and they may destroy the identifiable information form that I previously submitted.</p> <p>Signature of Biological Parent _____</p> <p>Current Name of Biological Parent _____ (Please Print)</p> <p>Complete Address _____ (Please Print)</p>		
SEAL	<p>Sworn (or affirmed) before me and subscribed in my presence this _____ day of _____, 19____, by the person whose signature appears above and whose identity is either personally known to me or satisfactorily proven to me.</p> <p style="text-align: right;">_____ SIGNATURE OF OFFICIAL ADMINISTERING OATH</p> <p><i>Please use stamp or print name, municipality, county, and commission expiration date below.</i></p>		