pennsylvania
DEPARTMENT OF HUMAN SERVICES

Pennsylvania Adoption Information Registry
Birth Parent/Birth Parent Survivor Authorization to Release Information and Registration Form

Completing this form is voluntary. However, 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.

NOTE: If you are submitting a request to Vital Records to redact your name on your birth child's noncertified copy of original birth record, you must complete sections I, II, III & VI.

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**	☐ Male ☐ 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 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:

☐ Birth child (when he or she turns 18)
☐ Birth child's descendants (if the birth child is deceased)
☐ Birth child's adoptive parents (if the birth child is under 18 or incapacitated)
☐ Birth child's birth grandparents provided the birth child is at least 21 or is adjudicated incapacitated or deceased.
☐ Birth child's legal guardian
☐ 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 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 my signature below, I am agreeing to the release of identifying information to the people checked above. 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

II. 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**

BIRTH MOTHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

Highest Grade Level Achieved	☐ High School	☐ Some College	☐ College	☐ Graduate Degree
I would Describe myself as:	☐ Lower Income	☐ Middle Income	☐ Upper Income	
Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children	☐ Boy #________________		☐ Girl # ________________	

Race/Ethnicity (Check all that apply)

☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Other__________________ Ethnicity Hispanic: ☐ Yes ☐ No

Height	Weight	Eye Color	Hair Color	Hair Type
				☐ Curly ☐ Straight

Complexion	Handedness
☐ Light ☐ Olive ☐ Medium ☐ Dark	☐ Right-handed ☐ Left-handed

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

Placed for Adoption ☐Yes ☐No	Name		Gender ☐Male ☐Female	Date of Birth	
City, State			Father's Name		
Placed for Adoption ☐Yes ☐No	Name		Gender ☐Male ☐Female	Date of Birth	
City, State			Father's Name		
Placed for Adoption ☐Yes ☐No	Name		Gender ☐Male ☐Female	Date of Birth	
City, State			Father's Name		
Placed for Adoption ☐Yes ☐No	Name		Gender ☐Male ☐Female	Date of Birth	
City, State			Father's Name		
Placed for Adoption ☐Yes ☐No	Name		Gender ☐Male ☐Female	Date of Birth	
City, State			Father's Name		
Placed for Adoption ☐Yes ☐No	Name		Gender ☐Male ☐Female	Date of Birth	
City, State			Father's Name		

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III. 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**

BIRTH FATHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

Highest Grade Level Achieved	☐ High School	☐ Some College	☐ College	☐ Graduate Degree
I would describe myself as:	☐ Lower Income	☐ Middle Income	☐ Upper Income	
Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children	☐ Boy #________________		☐ Girl # ________________	

Race/Ethnicity (Check all that apply)

☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Other___________________ Ethnicity Hispanic: ☐ Yes ☐ No

Height	Weight	Eye Color	Hair Color	Hair Type
				☐ Curly ☐ Straight

Complexion	Handedness
☐ Light ☐ Olive ☐ Medium ☐ Dark	☐ Right-handed ☐ Left-handed

BIRTH FATHER'S OTHER CHILDREN – (IDENTIFYING) Use Additional Page if Needed

Placed for Adoption ☐Yes ☐No	**Name**		**Gender** ☐Male ☐Female	**Date of Birth**	
City, State			**Mother's Name**		
Placed for Adoption ☐Yes ☐No	**Name**		**Gender** ☐Male ☐Female	**Date of Birth**	
City, State			**Mother's Name**		
Placed for Adoption ☐Yes ☐No	**Name**		**Gender** ☐Male ☐Female	**Date of Birth**	
City, State			**Mother's Name**		
Placed for Adoption ☐Yes ☐No	**Name**		**Gender** ☐Male ☐Female	**Date of Birth**	
City, State			**Mother's Name**		
Placed for Adoption ☐Yes ☐No	**Name**		**Gender** ☐Male ☐Female	**Date of Birth**	
City, State			**Mother's Name**		
Placed for Adoption ☐Yes ☐No	**Name**		**Gender** ☐Male ☐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**
		☐ Twins ☐ Triplets ☐ Other: _____

History of Reproductive System Problems ☐ YES ☐ NO (If YES, check all that apply below)

☐ Irregular Periods ☐ Painful Periods ☐ Fibroid Tumors (Benign) ☐ Ovarian Cysts (Benign)

☐ Endometriosis ☐ Other _____

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

Complications during this pregnancy? ☐ YES ☐ NO (If YES, check all that apply below)

☐ Bleeding ☐ Toxemia ☐ Urinary Tract Infections ☐ Gestational Diabetes ☐ Other _____

Any injury during pregnancy? ☐ YES ☐ NO (If YES, describe below.)

X-ray procedures during pregnancy? ☐ YES ☐ NO (If YES, Month of Pregnancy_____)

If YES, purpose of X-Ray:

Diseases during pregnancy? ☐ YES ☐ NO (If YES, list below.)

Disease	Treatment

Length of pregnancy?

☐ Premature - Number of weeks early: _____

☐ Full-Term ☐ Post-Term - Number of weeks late: _____

Tobacco use during pregnancy? ☐ YES ☐ NO (If YES, Average number of cigarettes daily:_____)

Alcohol use during pregnancy? ☐ YES ☐ 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** ☐ Spontaneous ☐ Forceps ☐ Breech ☐ Caesarean

Complications during delivery? ☐ YES ☐ 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: ☐ Hereditary ☐ Non-hereditary Type: ☐ Partial ☐ Total							
DEAFNESS Cause: ☐ Hereditary ☐ Non-hereditary Type: ☐ Partial ☐ 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: ☐ Overactive Thyroid ☐ Underactive Thyroid ☐ Goiter ☐ Iodine Deficiency							
PITUITARY GLAND DISORDER Specify: ☐ Excessive hormone ☐ Reduced hormone ☐ Growth Hormone Deficiency							
OTHER (specify):							
Intellectual & Developmental Conditions							
DOWN SYNDROME							
PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM							
MENTAL RETARDATION Cause: ☐ Hereditary ☐ Non-hereditary							
SPEECH/COMMUNICATION DISORDER Cause: ☐ Brain damage ☐ Developmental delay ☐ Structural abnormality (mouth)							
LEARNING DISORDER Specify: ☐ Dyslexia (reading) ☐ Dysgraphia (writing) ☐ 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 (MANICDEPRESSIVE)				POST-TRAUMATIC STRESS DISORDER			
ALCOHOLISM				ANOREXIA NERVOSA			
OBSESSIVE COMPULSIVE DISORDER							
OTHER (specify):							
Gastrointestinal Urinary System Conditions							
KIDNEY DISEASE Cause: ☐ Hereditary ☐ Non-hereditary							
LIVER DYSFUNCTION Cause: ☐ Hereditary ☐ Non-hereditary							
GALL BLADDER DISORDER ☐ Gall stones ☐ Infection ☐ Tumor							
ULCERS							
DIVERTICULITIS							
ULCERATIVE COLITIS/CROHN'S DISEASE							
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
Cancer							
BLOOD (Leukemia)				BRAIN			
COLON				HODGKN'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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