Department of Health

Authorization of Release of Adopted Name

This form is prescribed for the purpose of authorizing the release of identifying information pertaining to the adopted person to the birth parent or birth sibling when the adopted person reaches the age of twenty-one (21) or older in accordance with 3107.48 of the Revised Code. I realize that the purpose of this request is to enable the birth parent or birth sibling to obtain identifying information pertaining to me. **Two forms of identification such as motor vehicle or commercial driver's license, identification card, marriage application, social security card, military identification card, or employee identification card must be submitted with the Authorization of Release of Adopted Name.**

I also realize that I may rescind this request by submitting a Rescission of Authorization of Release of Adopted Name form and I may request and rescind that request as often as I wish.

TYPE OR PRINT LEGIBLY
Adopted Child's Information as listed after the adoption was finalized.

Name after Adoption _____

Date of Birth _____

Place of Birth (City, County) _____

_____ _____
Signature of Adopted Person **Date**

_____
Street Address

_____ _____ _____
City **State** **ZIP**

Sworn to before me and subscribed in my presence, this _____ day of _____, 20_____.
(Day) **(Month)** **(Year)**

_____ _____
(Signature of Notary Public) **(Date commission expires)**

— This form must be notarized prior to submission —

The completed authorization form should be mailed to:
Ohio Department of Health
Attn: Special Registration
P.O. Box 15098
Columbus, Ohio 43215