State of Illinois
Illinois Department of Public Health

Illinois Adoption Registry and Medical Information Exchange (IARMIE)
REQUEST FOR A NON-CERTIFIED COPY OF AN ORIGINAL BIRTH CERTIFICATE

I, _____, hereby request a non-certified copy of

(check the appropriate option):

❑ 1. My original birth certificate. Notary **NOT** required.

❑ 2. The original birth certificate of my deceased adopted or surrendered parent or grandparent. **Notary required/below.**

❑ 3. The original birth certificate of my deceased adopted or surrendered spouse. **Notary required/below.**

The adopted or surrendered person was born in the city of_____,

county of_____ on _____, _____ and the adopted name is:
Date Year

First name _____ Middle name _____

Last name _____

In the event that one or both of the birth parents have requested their identity not be released:

❑ a. I wish to receive a non-certified copy of the original birth certificate from which identifying information pertaining to my birth parents, who requested anonymity, has been redacted; or

❑ b. I do not wish to receive a redacted copy of the original birth certificate.

NOTE:
Regardless of your selection above, all options require that you submit a copy of a non-expired, government issued photo ID and a check or money order made to IDPH for $15.

If you selected option 2 or 3, you must be registered with the IARMIE as a surviving relative of the deceased adopted or surrendered person. If you need to register, please contact the IARMIE at 877-323-5299.

_____ _____
Signature Date

Mailing address _____ City _____

State _____ ZIP code _____

Notary required if you checked option 2 or 3 above.

(Notary Public use only)

State of _____ County of _____

I, a Notary Public, in and for the said county, in the state aforesaid, do hereby certify that

_____ personally known to me to be the same person whose name is subscribed to the foregoing request, appeared before me in person and acknowledged that (he or she) signed such request as (his or her) free and voluntary act and that the statements in such request are true.

Given under my hand and notarial seal on _____, _____

_____

Mail to: Illinois Department of Public Health, Division of Vital Records - IARMIE, 110 West Lawrence Ave., Springfield, Illinois 62704-2610

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