Department of Health

Rescission of Authorization of Release of Adopted Name

This form is prescribed for the purpose of rescinding the Authorization of Release of Adopted Name. I realize that the purpose of this rescission is to cancel the Authorization of Release of Adopted Name form previously filed with the Department of Health. **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 Rescission of Authorization of Release Form.**

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

_____

Name (Last, First, Middle)

_____

Street Address

_____ _____ _____

City **State** **ZIP**

_____ _____

Signature **Date**

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