Ohio Department of Health • Vital Statistics

Request for Assistance by Adopted Person

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 and birth sibling to obtain identifying information pertaining to me.

I also realize that I may rescind this request by writing to the Department of Health and including a notarized statement with my address and two forms of identification.

I further realize that I may request assistance and rescind that request as often as I wish.

TYPE OR PRINT LEGIBLY

1. Adopted person's name after the adoption

Last	First	Middle

2. Adopted person's date of birth

Month	Day	Year

3. Current residence address

City		State	ZIP

Adopted person's signature

Signature	Date

Sworn to before me and subscribed in my presence, this _____ day of

_____ (month), 20 _____ (year)

Signature of Notary	Date commission expires

SEAL

— Instructions on reverse side —

HEA 3036 (Rev. 7/03)

APPENDIX BB
3701-5-02

Request for Assistance by Adopted Person
Instructions

Section 3107.48 of the Revised Code provides that an adopted person 21 years of age or older may file a request for assistance form which will authorize the Ohio Department of Health to assist the birth parent or birth sibling in finding the adopted person's name by adoption.

Instructions for completion of this form

1. **Adopted person's name after the adoption**—The full name of the adopted person after the adoption was finalized (include first, middle, last and any suffix).
2. **Adopted person's date of birth**—The date of birth which appears on your birth certificate after the adoption was finalized.
3. **Current residence address**—The complete address including street number and name, apartment # or Suite # (if applicable), City, State and ZIP Code.

— This form must be notarized prior to submission —

The completed request form should be mailed to:

Ohio Department of Health
Vital Statistics
35 East Chestnut Street
P.O. Box 118
Columbus, Ohio 43216-0118