

Ohio Department of Health
Rescission of Request for Assistance
by Adopted Person

This form is prescribed for the purpose of rescinding the request for assistance by adopted person. I realize that the purpose of this rescission is to cancel the Request for Assistance by Adopted Person form previously filed with the Department of Health. I understand that I must supply two forms of identification with this form.

I also realize that I may rescind this rescission by filing a new Request for Assistance by Adopted Person form and I may request and rescind that request as often as I wish.

Name	first	middle	last
Address street and number			
City	State		ZIP

Signature	Date
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Sworn to before me and subscribed in my presence, this _____ day of _____, 20____
(month) (year)

(Signature of Notary Public) (Date commission expires)

— Must be submitted with two forms of identification —