

AFFIDAVIT OF DISCLOSURE OR NON-DISCLOSURE

REGARDING AN ORIGINAL BIRTH RECORD OF AN ADOPTED PERSON

Adopted people may request information about their birth parents when they are 19 years old or older. Whether to release information to the adopted person is up to each parent named on the original birth record. Birth parents may make different decisions. Each parent named on the original birth record may fill out this form and send it to the Office of Vital Records *at any time*. The Office of Vital Records keeps the forms on file.

Biological parent information - to locate the original birth record			
Your name must be on the adopted person's original birth record			
Biological parent	Your first name	Last name before 1 st marriage	Your current last name
	Your birth date (MM/DD/YYYY)		
	Your street address	City	State
	ZIP Code™		
Name of other biological parent			
Adopted person's birth record information BEFORE the adoption			
Adopted person	Adopted person's name before adoption		Adopted person's name after adoption (if known)
	Adopted person's date of birth (MM/DD/YYYY)	Adopted person's city and county of birth in Minnesota	
Decision to disclose information recorded on the original birth record when the adopted person has reached the age of 19			
<i>Minnesota Statutes, Section 259.89, subdivision 2, item (4)</i>			
Do you want to disclose your information? Select Yes or No		<input type="checkbox"/> Yes, I permit you to release information from the original birth record. <input type="checkbox"/> No, do not release information from the original birth record.	
Decision to release address to adopted person			
Do you want to release your address? Select Yes or No		<input type="checkbox"/> Yes, give my address, as listed on this form, to the adopted person. <input type="checkbox"/> No, do not give my address to the adopted person.	
Signature and notary information			
I certify that the information provided on this document is accurate and complete to the best of my knowledge.			
Signature of biological parent			Notary stamp/seal
I am the biological mother <input type="checkbox"/> . I am the biological father <input type="checkbox"/> .			
Sworn/affirmed to before me on _____ day of _____, 20____			
Notary public printed name			
Notary public signature		My commission expires	
Mail this form:		Do you have questions?	
Minnesota Department of Health Office of Vital Records PO Box 64499 St. Paul, MN 55164-0499		Contact the Office of Vital Records at 651-201-5970 or health.vitalrecords@state.mn.us	