



AFFIDAVIT OF DISCLOSURE OR NON-DISCLOSURE REGARDING AN ORIGINAL BIRTH CERTIFICATE OF AN ADOPTED CHILD

I, _____ born on _____ state that I am
(Full Name - First, Maiden, Last) **(Date of Birth)**

the _____ named on the original birth certificate
(Biological Father/Mother)

of _____ , _____
(Child s Name) **(Adopted Name, If Known)**

born on _____ in _____
(Child s Date of Birth) **(City and County)**

I hereby _____ in accordance with Minnesota Statutes,
(Give Consent/Do Not Give Consent)

Section 259.89, subdivision 2, item (d) to full disclosure of the information contained on the original certificate when the child has reached the age of 19. I hereby _____
(Give Consent/Do Not Give Consent)

to the release of my address to the above mentioned child if the child is 19 years of age or older.

Signed or attested before me on

X _____
(Signature of Biological Mother/Father)

(Date)

X _____
(Street Address)

(Notary Public)

X _____
(City and State)

My Commission Expires _____

X _____
(Date)

Please Complete and Return to: Minnesota Department of Health
Office of the State Registrar
P.O. Box 64882
St. Paul, Minnesota 55164-0882