



MINNESOTA DEPARTMENT OF HEALTH  
 OFFICE OF THE STATE REGISTRAR  
 P.O. BOX 64499  
 ST. PAUL, MN 55164-0449



**FATHERS' ADOPTION REGISTRY  
 SEARCH REQUEST**

PROVIDE COURT FILE NUMBER, (if known) \_\_\_\_\_ MDH Birth File # (if known) \_\_\_\_\_

- I am requesting an **optional** search of the Registry as allowed by Minnesota Statutes, §259.52, subdivision 2, which may be performed at anytime, but if performed before the child is 30 days old, must be performed again a **minimum** of 31 days after the birth.
- I am requesting the **required** search of the Registry as allowed by Minnesota Statutes, §259.52, subdivision 2, which must be performed no sooner than the 31<sup>st</sup> day after the birth of the child who is the subject of the search.

<input type="checkbox"/> I am supervising the adoptive placement of the child named in this search request, as a representative of the <i>adoption agency</i> listed in the signatory section of this form.
<input type="checkbox"/> I am a representative of <i>the county social service agency</i> listed in the signatory section of this form, and responsible for completing a search of the MFAR relative to the child named in this search request, pursuant to Minn. Statutes, §259.53., Subd. 1
<input type="checkbox"/> I am a representative of the county social service agency that is the petitioner in a <i>juvenile protection matter</i> for the child named in this search request, pursuant to Minnesota Statutes, Chapter 260C
<input type="checkbox"/> I am an official responsible for establishing a <i>child support obligation</i> , in relation to the child named in this search request, pursuant to Minnesota Statutes 259.52, Subd. 3.
<input type="checkbox"/> I am an <i>Attorney</i> representing the biological mother or the prospective adoptive parents of the child named in this search request (attorney's must complete and attach the <i>Affidavit of Attorney and provide their attorney license #</i> _____).

**Please print. Do not add more than one child per search request.**

**CHILD:** Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
LAST, FIRST MIDDLE  
 Sex: \_\_\_\_\_ **or** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Total # of children on petition \_\_\_\_\_  
MALE FEMALE MONTH DAY YEAR Example 1 of 2

Place of Birth: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
HOSPITAL CITY STATE Zip

**BIOLOGICAL MOTHER:** Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
LAST, FIRST MIDDLE

Aliases: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, **Phone:** \_\_\_\_\_  
MONTH DAY YEAR Required.- if unknown, write in "unknown" and certify by signing below

Address: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
STREET APARTMENT # CITY STATE ZIP CODE

I am submitting this request in compliance with Minnesota Statutes, Section 259.52, Subd. 1, paragraph (b) clause 2, item (iii). All data shall be provided, as requested if the information is known. Name, address, social security number, and other data provided to the Minnesota Fathers' Adoption Registry, will be used as part of the verification and notification process for the putative father identified, or as used as documentation that no putative father was identified. This information may only be used for purposes authorized under Minnesota Statutes, section 259.52 or other law.

I, \_\_\_\_\_, \_\_\_\_\_ have the authority to make this request.  
NAME TITLE

\_\_\_\_\_  
SIGNATURE AGENCY / COUNTY / ATTORNEY DATE

\_\_\_\_\_  
STREET CITY STATE ZIP CODE TELEPHONE

There is a \$ 25 fee to search the MFAR. Make your check or money order payable to the Minnesota Department of Health. Checks returned for non-payment will be charged a \$ 30.00 fee according to Minn. Statutes, section 604.113, subdivision 2. Mail application and payment to: Minnesota Department of Health, Office of the State Registrar, Fathers Adoption Registry, P.O. Box, 64499, St. Paul, MN 55164-0499.

Card Number \_\_\_\_\_

Expiration Date: \_\_\_\_\_