Ohio Department of Health

Authorization of Release of Adopted Name

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 or birth sibling to obtain identifying information pertaining to me. This form must be submitted with two forms of identification.

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

TYPE OR PRINT LEGIBLY

Adopted Child's Information as listed after the adoption was finalized.

Name after Adoption_____

Date of Birth_____

Place of Birth (city, county)_____

_____

Signature of adopted person Date

_____

Street Address City State Zip Code

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

_____, 20 _____ .

(month) (year)

Signature of Notary	Date commission expires

SEAL

— This form must be notarized prior to submission —

The completed authorization form should be mailed to:

Ohio Department of Health
Vital Statistics
P.O. Box 15098
Columbus, Ohio 43215

HEA 3036 (Rev. 03/14)