

New York State
Department of Health

Adoption Information Registry
Birth Parent Registration Form

COMPLETE THIS APPLICATION
AND RETURN TO:

New York State Department of Health
Adoption Information Registry
P.O. Box 2602
Albany, NY 12220-2602
(518) 474-9600

REGISTRY NUMBER _____
DATE _____

OFFICIAL USE ONLY

*Check both boxes if you are searching
and want to give/receive as much
information as possible.*

Please indicate if this registration is to: (check all that apply)

- Register for identifying information (Adoptee must be 18 years of age or older)
 Submit medical information diagnosed after the adoption (No age restriction)

Medical information must be submitted on medical care provider's letterhead and include: medical care provider's name, address, telephone number, and signature.

1. Name and address of birth mother

LAST FIRST MIDDLE MAIDEN
CURRENT MAILING ADDRESS STREET CITY/TOWN
()
STATE ZIP CODE CURRENT TELEPHONE NUMBER
BIRTH MOTHER'S DATE OF BIRTH
MONTH DAY YEAR

2. Were you married at the time of the child's birth? YES NO

IF YES, NAME OF HUSBAND _____

3. List any other name you may have been using at the time of the child's birth, (i.e., former married name, assumed name, alias, etc.)

4. Name and address of birth father

LAST FIRST MIDDLE BIRTH FATHER'S DATE OF BIRTH
MONTH DAY YEAR
CURRENT MAILING ADDRESS STREET CITY/TOWN
()
STATE ZIP CODE CURRENT TELEPHONE NUMBER

New York State
Department of Health

Adoption Information Registry
Adoptee Registration Form

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Adoption Information Registry
P.O. Box 2602
Albany, New York 12220-2602
(518)474-9600

REGISTRY NUMBER _____

DATE _____

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*check every box if you are searching
and want as much information
as possible.*

NOTE: This registration can be accepted only if the adoptee was born and adopted in New York State. Complete as much information as possible and include a copy of adoptee's birth certificate and adoption order, if available.

Please indicate if this registration is for: (check all that apply)

- Non-identifying information (*) -- Available general and medical information about biological parents at time of adoption.
- Non-identifying Medical Information (**) -- Updated medical information, if/when submitted by biological parents after the adoption.
- Identifying information (*) - About biological parents, if/when registered.
- Identifying Information (*) - About biological siblings, if/when registered.

(*) Adoptee must be 18 years of age or older.

(**) No age restriction, but adoptive parent must sign this registration, if adoptee is under 18 years of age.

Note: If the Adoption Registry determines that an agency was involved in your adoption, non-identifying and identifying information will be released to you by the agency. Check box if you do not want the information released by the agency that handled your adoption. If the box is checked, the New York State Department of Health will obtain the information from the agency and share it with you.

PLEASE COMPLETE ALL INFORMATION. MISSING INFORMATION MAY DELAY PROCESSING.

1. Name and address of adoptee

LAST FIRST MIDDLE MAIDEN
MAILING ADDRESS STREET CITY/TOWN
STATE ZIP CODE TELEPHONE NUMBER

2. Date of birth of adoptee

MONTH DAY YEAR

*If you leave this box
unchecked, then you will
get information directly from
the agency. Recommended -
otherwise, state might redact some info
as "identifying."*

3. Adoptive parents

A. MOTHER: LAST FIRST MIDDLE MAIDEN

B. FATHER: LAST FIRST MIDDLE

C. ADDRESS AT TIME OF ADOPTION, if known STREET CITY/TOWN

STATE ZIP CODE

4. Place of birth of adoptee

HOSPITAL, if known

CITY, TOWN OR VILLAGE COUNTY/BOROUGH

**New York State
Department of Health**

**Adoption Information Registry
Biological Sibling Registration Form**

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REGISTRY NUMBER _____
DATE _____

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NOTE: This registration can be accepted only if the adoptee was **born and adopted** in New York State. **Complete as much information as possible and include a copy of your birth certificate listing your parent's names.**

If the Adoption Registry determines that an agency was involved in the adoption, information will be released to you by the agency.
 Check box, if you do not want the information released by the agency that handled the adoption. If the box is checked, the New York State Department of Health will obtain the information from the agency and share it with you.

See notes to Adoptee Registration Form

1. Information about you, i.e., the person registering

LAST FIRST MIDDLE MAIDEN
MAILING ADDRESS STREET CITY/TOWN
STATE ZIP CODE TELEPHONE NUMBER

Date of birth MONTH DAY YEAR EMAIL ADDRESS

Place of birth CITY STATE

Parents

MOTHER: LAST FIRST MIDDLE MAIDEN
FATHER: LAST FIRST MIDDLE

2. Information about adoptee

LAST FIRST MIDDLE

Date of birth MONTH DAY YEAR

Place of birth of adoptee CITY STATE

Birth parents

MOTHER: LAST FIRST MIDDLE MAIDEN
FATHER: LAST FIRST MIDDLE